CHILDREN WITH SEVERE EMOTIONAL DISABILITIES

Criterion 1: Comprehensive Community Based Mental Health Services System

The plan provides for the establishment of an organized, community-based system of care for children including health, mental health and rehabilitation services, employment, housing, educational, medical, dental, substance abuse treatment, support services, services provided by local school systems under IDEA, case management, and services for co-occurring (MH/SA) disorders, which enable such individuals to function outside of inpatient or residential institutions.

GOAL: To ensure that all children with severe emotional disabilities, and their families, receive the most appropriate and effective services, in the least restrictive environment.

INTRODUCTION

The Kentucky Department for Mental Health and Mental Retardation Services (KDMHMRS) administers a comprehensive, community-based system of mental health care for children with severe emotional disabilities (SED), and their families. With guidance from the Surgeon General's Report on Children and Mental Health[1], the New Freedom Commission Report[2] and Healthy Kentuckians 2010[3], the department strives to further promote the Children's System of Care principles and objectives, while at the same time ensuring autonomy at the regional level for service planning and decision-making.

Regional Mental Health/Mental Retardation Boards (Regional Boards), in conjunction with Regional Planning Councils (RPCs), which are comprised of at least 51% consumers and family members, are required to specifically describe their current children's system of care and to state their plans for development regarding four key system components. These are:

- Family Involvement and Support
- Clinical Services
- Service Coordination
- Systems Interface

KDMHMRS is committed to working collaboratively with Regional Boards to continuously enhance continuity of care, service effectiveness and accountability. Current activities regarding each of these four components are discussed below, offering detail from a regional and state level perspective. Related goals and action plans for targeted components are discussed collectively at the end of Criterion 1.

Component 1: Family Involvement and Support

REGIONAL PERSPECTIVE

Across all regions of Kentucky, parents' voices are most consistently heard through their membership on Local and Regional Interagency Councils. These Councils are responsible for the identification of children with SED and for coordination of the services that they receive. These representatives also make up the State Family Advisory Council (SFAC), which serves in an advisory capacity to the State Interagency Council to Children with an Emotional Disability (SIAC).

Citations:

1. U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action
Agenda. Washington, DC: 2000
2. New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America.*
Final Report. DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003
3. Healthy Kentuckians 2010. Kentucky Cabinet for Health and Family Services, 2001.

The majority of regional IMPACT programs, which serve children with SED and their families, also have staff positions of "Family Liaison." These individuals provide peer-to-peer mentoring, facilitate the creation and maintenance of local parent support groups/family network activities, provide education and offer technical assistance on a variety of topics to families and service providers.

A review of the information from the SFY 2005 Annual Plan and Budget applications submitted by Regional Boards reveals that there are ongoing efforts to maintain and increase family involvement at all levels of the service system, including:

- Parents participating on Regional Planning Councils in all fourteen regions and serving on various regional and state level policy and program development committees;
- A growing number of "grandparents raising grandchildren" support efforts;
- Regions creatively building their consumer networks and providing for parent input into programming and future planning for children's programming;
- At least one parent support group is active in twelve regions and there are six support groups across the state for transition age youth;
- A parent newsletter is regularly published in eight regions;
- A resource library either dedicated for use by parents or available to parents and staff in ten regions;
- Parents acting as evaluators for several initiatives and participating in focus groups to analyze data gathered; and
- Provision of parenting skills training for parents/family members, and sponsored "family fun events" for children and families, in most regions.

During the Annual Plan and Budget application process in April 2004, the Regional Boards reported the following Plans for Development, for their respective region. Only one plan per criterion was required therefore not all regions chose to address this component within Criterion 1.

Region	Plan for Development for SFY 2005
2	Provide support services to families involved in children's crisis services and provide direct services for families whose children are involved in the Therapeutic Foster Care (TFC) program.
3	Support Groups: Foster Parent Support Group-Monthly Parent Support Training- Annually
9/10	Expand availability of parent support groups. Hire and train another Family Liaison
13	Assess current support network throughout the region. Develop, implement and evaluate a parent survey to identify needs of each county by 9-04. Establish support groups in needed counties by 7-05.

STATE PERSPECTIVE

It is the belief of KDMHMRS that parents' voices should help shape not only individual treatment decisions, but also program development and policy determinations at the local, regional, and state levels. This principle is strengthened by the advocacy efforts of parents at various points in the system of care. In support of this vision, significant portions of state general funds and 16.5 percent of the children's portion of CMHS Block Grant funds are allocated to parent initiatives at each level.

Within KDMHMRS is a unit known as Opportunities for Family Leadership (OFL). It provides numerous services for families and the systems that serve them, including:

- Training in advocacy, communication, cultural competency, collaboration and legal rights in schools;
- Awarding mini-grants for parent support groups to develop local training (over 200 training events were funded in SFY 2004);
- Providing technical assistance to ensure Standards of Practice for Family Liaisons across the state are met and approves required trainings per the Standards of Practice;
- Distributing reader friendly versions of Client Rights and Grievance Procedures, and supporting documents, to parents and others to ensure that these policies and procedures are understood by everyone; and
- Providing technical assistance to other advocacy organizations and individuals with regard to mental health, mental retardation and substance abuse services and supports. Resource information and training opportunities are among the many items provided on OFL's web site at www.mhmr.chs.ky.gov/family.

The Kentucky Partnership for Families and Children (KPFC) is a statewide organization dedicated to improving services for children with emotional, behavioral and/or mental health disabilities by providing support, education and advocacy to youth and families. There are over 1,500 members statewide. Their Board of Directors is comprised of 30 members, with 60% being parent representatives. Activities of the KPFC include:

- Dissemination of printed information and a quarterly newsletter;
- Participation on numerous interdisciplinary committees;
- Operation of a web site (www:kypartnership.org) and a toll-free phone number (800-369-0533) for parents to access information about KPFC and resource information statewide;

- Distribution of scholarships for parents and youth to attend conferences and other advocacy events;
- Operation of parent support chat rooms twice a month;
- Formation of a statewide Youth Council comprised of 14-25 year olds who have an emotional disability/mental illness; and
- Formation of Regional Youth Councils (6) in partnership with Regional Boards to replicate the model.

Component 2: Clinical Services

REGIONAL PERSPECTIVE

All Regional Boards have a designated Children's Services Director. These Directors, along with others, seek to ensure that the mental health service needs of children and families in their service region are assessed, addressed and evaluated in a structured, yet flexible manner. Such services are designed to address the holistic needs of children with SED, as well as those of the general population of children served in their region.

A review of the information from the SFY 2005 Annual Plan and Budget applications reveals that Regional Boards continually strive to address barriers and meet the clinical service needs of children and families. Some examples of this include:

- Twelve regions offer therapy appointments during evening hours in at least one of their office sites, and seven offer services during weekend hours;
- All regions offer walk-in appointments for children/families in crisis;
- Most regions formally include crisis planning in the treatment planning process;
- All regions offer services off-site, with all offering school-based services in the majority of counties in their region and the majority offering in-home services in most counties;
- All regions employ a designated Child Sexual Abuse Coordinator; and
- All regions employ a Coordinator designated for Early Childhood Mental Health Services and serve children of all ages, including infants.

The table below represents an overview of the Available Services Array for Children provided by each of the fourteen Regional Boards across the state.

Children's Array of Services: Availability by Region from Plan and Budget Application for SFY 2005

Services		Clinical Services *	Psychiatry **	Early Childhood Specialist	Service Coordination	Therapeutic Child Support Services	School Based Services	Intensive In-Home	After-School Program	Specialized Summer Program	Crisis Stabilization Program	Day Treatment Program	Therapeutic Foster Home(s)	Partial Hospitalization Program	Other (please specify)
Regions	1	X	X	X	X	X					X			X	
	2	X	X	X	X	X	X	X		X	X		X		
	3	X	X	X	X	X	X	X	X				X	X	
	4	X	X	X	X	X	X		X	X	X	X	X		
	5	X	X	X	X		X		X	X	X				
	6	X	X	X	X	X	X	X	X	X	X	X		X	
	7	X	X	X	X	X	X			X	X	X		X	
	8	X	X	X	X	X	X			X	X				
	9/ 10	X	X	X	X	X	X	X	X	X	X	X			X***
	11	X	X	X	X	X	X			X	X	X			
	12	X	X	X	X	X	X	X	X	X	X	X	X		X ****
	13	X	X	X	X	X	X	X	X	X	X				
	14	X	X	X	X	X	X		X	X	X	X	X		
	15	X	X	X	X	X	X		X	X	X		X		

* At least 50% of time dedicated to services for children and families

** At least one year of specialized child training

*** Region 9/10 Other: Child Advocacy Center & Reactive Sexual Behavior Treatment Program

**** Region 12 Other: Co-occurring MH/SA Services

During the Annual Plan and Budget application process in April 2004, the Regional Boards reported the following Plans for Development, for their respective region. Only one plan per criterion was required therefore not all regions chose to address this component within Criterion 1.

Region	Plan for Development for SFY 2005
1	Establish a well-equipped Play Therapy Chamber in the southern counties of the region.
2	Provide specific children's services by trained therapists in each of the four area clinics of the Pennyroyal Center.
4	Increase intensive community-based services in all 10 counties of the region. Increase the number of behavior health specialists to provide treatment. Provide training in assessment and client-centered, cognitive behavioral techniques.
7	Therapeutic Aides in the IMPACT program will receive, at a minimum, two (2) trainings focused on Early Childhood issues/interventions.
8	Align the IMPACT program and School-based Mental Health program using Positive Behavioral Interventions and Support (PBIS) program philosophy and methods into daily practice. Form a basis of understanding on PBIS throughout the region by educating a core group of children's services staff who can advocate for implementation across the region.
12	Implement an intensive continuing care model for youth with SED or co-occurring disorders. Identify intensive continuing care models and chose at least one. Train and implement the model in at least one county of the region.

STATE PERSPECTIVE

KDMHMRS lends on-going technical support to Regional Boards to ensure quality service delivery for children and families. The majority of the Division staff within KDMHMRS is licensed mental health professionals and had previously been employed by Regional Boards or other providers of various services for children with SED. Thus, they bring first hand knowledge and perspective to their role as liaisons to the Regional Boards.

KDMHMRS is committed to "moving forward" the knowledge and skill level of clinical service providers to ensure that clients and families receive quality mental health services that promote resiliency and recovery. The department strives to accomplish this by:

- Assessing current policy/philosophy and practice of the Regional Boards, as well as keeping abreast of such among other child serving agencies;
- Providing formal and informal technical assistance, training, and encouraging two-way dialogue among the department staff and Regional Boards about a full range of clinical issues; and
- Proposing and implementing policy and legislation and seeking funding to enable movement towards an optimal children's system of care. Often this is best achieved through formal and informal partnerships with other child-serving state agencies. Partnerships with colleges and universities and the business community are also deemed beneficial to achieving stated goals.

Currently, the department is focusing resources on the following items to achieve its goals:

- Research-based clinical practices;
- Efficacious assessment and outcomes tools;
- Diagnosis-specific treatment protocols;
- Deduction of seclusion and restraint practices;
- Client-driven treatment planning and service delivery;
- Prevention and early intervention services;
- Co-morbid health issues (obesity, suicidal ideation, abuse and neglect);
- Co-occurring disorders (mental health/ substance abuse and mental health/mental retardation);
- Services for victims and perpetrators of abuse, neglect and sexual assault;
- Transition services (youth to adulthood);
- Education and employment;
- Custody relinquishment for the purpose of obtaining services;
- Physical and dental health screenings and referral protocols; and
- Crisis intervention services.

Current activities concerning several of these items are discussed below and are also addressed under *Action Plans* at the end of Criterion 1.

Early Childhood Mental Health
The President's New Freedom Commission on Mental Health recommends that states "promote the mental health of young children." This requires specialized training of clinical, administrative, and case management staff. While the Early Childhood Mental Health (ECMH) Initiative has improved both training of clinicians in the area of infant and early childhood mental health and access to these services for families of young children, there remains a general lack of knowledge in this area on the part of clinicians and administrators. Further, an objective evaluation of the program has not yet been implemented in order to track program outcomes or client improvement over time. In SFY 2003, expansion funds were allocated to each Regional Board to hire an ECMH Specialist to work with children age birth to five years, and their families. The specialists provide consultation, assessments and direct treatment services.

School-Based Mental Health
Currently there are numerous school-based mental health initiatives across the state. Various models for school-based and off-site service provision continue to be studied and assessed for feasibility and effectiveness. KDMHMRS has sponsored several training seminars featuring national presenters to educate personnel of the Regional Boards and school districts. These have been well attended and help to keep the momentum going.

The current emphasis in the area of school-based mental health is on an integrated, multi-tiered approach that includes mental health promotion, early intervention, and intensive interventions. For several years KDMHMRS and Kentucky Department of Education (KDE) have been implementing parallel programs based on the Positive Behavior Interventions and Supports (PBIS) model through the Bridges Project, KDE Model Schools and KIDS initiatives. KDE is currently implementing the Instructional Discipline Pilot Program (IDPP), based on the PBIS philosophy, in all school districts across the state. This program is based on a three-tiered prevention model. The PBIS model encourages the involvement of mental health staff and parents at every level of intervention and support (universal/primary, targeted/secondary, and intensive/tertiary.) Staff from the DMH and the SIAC has served on the IDPP planning and steering committees, During SFY 2004, KDE and DMH offered several cross-training opportunities to educators and clinicians on this model. Through the Memorandum of Agreement between KDE and DMH, a staff member of DMH serves as a co-evaluator for the IDPP project at .25 FTE.

Physical and Dental Health and Vision Care
Regional Boards are required to conduct physical health screening with all clients served. Department staff has assisted several regions with improving tools used to assess physical health concerns and continues to encourage further assessment and integration of physical and mental health care.

According to the Centers for Disease Control, thirty-five percent of low-income children between two and five years of age in Kentucky are overweight or at risk for becoming overweight. Obesity among Kentuckians is epidemic and Kentucky's children and overall population are among the most obese in the nation. Currently, a statewide plan to address this epidemic is being drafted by the Department for Public Health in cooperation with Local Health Departments, state agencies including DMH and other community partners. This work is supported by a grant from the Centers for Disease Control and Prevention. More information about this initiative can be found on the web site FitKY.org. One Regional Board in the state, where obesity is quite prevalent among both its adult and child populations, has committed staff time and training funds to addressing the obesity and mental health connection in their own region and are sharing information statewide.

For dental care, access to low or no cost services provided by the University of Louisville and University of Kentucky dental schools serves as a resource in urban areas. Once again, case managers and clinicians that have knowledge of local resources and well-developed relationships with providers tend to lead to better access to dental services. There are, in many communities, those dentists who will serve children in need who have no ability to pay for dental care. However, overall access is generally considered poor. The department does have representatives on several committees exploring dental services to children and how best to ensure outreach and treatment services to young children and children in the custodial care of the state. Several pieces of legislation were introduced in the last session of the Kentucky General Assembly to remove barriers to dentists' ability to provide low or no cost services but none were enacted.

All Kentucky children are required to have an eye exam by a Board Certified Optometrist before they enter school. This is in addition to the requirement for immunizations and hearing screenings.

Child Welfare and Legal Interface
Regional Boards give priority to clients referred by the Department for Community Based Services and the Department for Juvenile Justice. In many areas, formal and informal collaborative meetings are held to discuss

treatment planning for shared clients. Clinicians also offer mental health consultation to the staff of these two Departments. Child welfare and juvenile justice are represented on the SIAC and all RIACs. Recently, the department was facilitated a work group to define and set protocols for Emotional Injury in children.

Substance Abuse Services
Substance use/abuse among children and adolescents, and their caregivers, is often identified by Regional Board clinicians as a contributing factor to the mental health needs of clients they serve. The use and abuse of nicotine, alcohol, inhalants, prescription and illegal drugs is addressed in the treatment provided. Clinicians and case managers also utilize education (prevention and intervention), treatment and referral mechanisms available through school districts, law enforcement agencies, private providers and Regional Board Prevention programs.

Component 3: Service Coordination

REGIONAL PERSPECTIVE
In Kentucky, targeted case management services for children through the Kentucky IMPACT program are referred to as "Service Coordination" provided by "Service Coordinators." Kentucky IMPACT is a strengths-based, highly individualized, and collaborative model of case management utilizing Wraparound to address needs across life domains. These life domains include family, financial, living situations, educational/vocational, behavioral/emotional, psychological, social/recreational, health, legal, cultural and safety.

Legislation enacted in 1990 created eighteen Regional Interagency Councils (RIACs) that govern the regional IMPACT programs (see map below.) Each RIAC is comprised of local representatives from the primary child serving agencies and a parent of a child with SED. A Local Resource Coordinator (LRC) serves as staff to the RIAC, and generally manages the regional IMPACT program. While Regional Boards employ the LRC, and IMPACT staff, each RIAC creates and monitors program policy and procedures and provides on-going consultation to the staff of their IMPACT program.

Three regions who initially received funding for demonstration projects to address services for transitioning from child to adult services, and several additional regions have developed services that are addressing the needs of transitioning youth. These include:
- Peer support groups for adolescents;
- Independent Living Skills training for 14-21 year olds;
- Vocational planning workshops;
- Life mapping workshops; and
- Consulting with adult case managers to ensure the smooth transition to needed services for youth reaching age eighteen.

Each RIAC serves as the gatekeeper for children entering and exiting IMPACT services. Each RIAC receives an annual per capita allocation from KDMHMRS for Service Coordination, RIAC staff support, and resource development. In consultation with its corresponding Regional Board, each RIAC determines how the funds will be obligated for the support of service delivery. Eligibility criteria for acceptance of a child into IMPACT is not determined by insurance coverage or a family's ability to pay.

Flexible funds, set aside by RIACs, may be used to purchase needed goods and services when there is no other available resource. Common expenditures may include tutoring services, summer camp fees, or therapeutic interventions provided to children by trained professional or paraprofessional mentoring staff. Regional Boards act as the fiscal agents for the funds but, again, decision-making authority regarding the use of these funds rests with each RIAC.

There are currently 240 Service Coordinators statewide and IMPACT has served 18,335 children from its inception through the end of SFY 2003. During SFY 2003, 5,540 children were served and projections are to serve an increased number, albeit small, in SFY 2004 and 2005.

While having an SED diagnosis is a part of the IMPACT program's eligibility criteria, many IMPACT clients also have the following characteristics:
- Co-occurring Mental Health/Mental Retardation diagnoses;
- Co-occurring Mental Health/Substance Abuse diagnoses;
- Pervasive Developmental Disorders, including Autism;
- Living in poverty;

- Living in Foster Care/Treatment Foster Care;
- Transitioning to Adulthood; and
- Homelessness or unstable living environments.

During the Annual Plan and Budget application process in April 2004, the Regional Boards reported the following Plans for Development, for their respective region. Only one plan per criterion was required therefore not all regions chose to address this component within Criterion 1.

Region	Plan for Development for SFY 2005
2	Dedicate two full-time Service Coordinators to work with families whose children are receiving crisis or TFC services. Ensure capacity of the Pennyroyal Center to meet the goal of immediate availability of IMPACT services for any child nominated and approved. Evaluate and assess the caseloads of each Service Coordinator to ensure that each is working at optimal capacity.
5	Increase the number of consumers served through Service Coordination by 25% for the period of July 2004 –June 2005. Employ three (3) additional Service Coordinators for the region. Increase the number of referrals on a quarterly basis.
7	In keeping with one of the Board's Regional Planning Council's priorities, increase the availability of IMPACT services. Hire two additional Service Coordinators and two additional Therapeutic Aides during SFY 2005.
8	Align the IMPACT program and School-based Mental Health program using Positive Behavioral Interventions and Support (PBIS) program philosophy and methods into daily practice. Train IMPACT staff on the problem solving model, family engagement and behavioral analysis proponents of PBIS.
11	Increase the number of Service Coordinators to eleven (11) by June 2005. Evaluate the number of qualified applicants for Service Coordinator positions and evaluate the number of children eligible for case management services that are not currently receiving that service.

STATE PERSPECTIVE

KDMHMRS provides technical assistance to LRCs that manage the IMPACT programs by assisting with quarterly peer meetings. Department staff also offers ongoing technical assistance and consultation to RIACs, LRCs, Service Coordinators and others.

Both KDMHMRS and Kentucky Medicaid help to ensure the integrity of IMPACT's Service Coordination program standards by:

- Requiring Service Coordinators to complete certification training conducted by KDMHMRS within six months of their employment;
- Imposing caseload size restrictions;
- Prohibiting Service Coordinators from providing billable services other than Case Management;
- Requiring Service Coordinators to have a minimum of four client-related contacts per month, two of which must be face-to-face contacts with the child and his/her family, for a reimbursable service; and
- Defining what does and does not constitute an appropriate case management activity.

A ten-year evaluation report completed in September 2001 confirms the efficacy of the IMPACT program. Currently there are efforts underway to overhaul the evaluation system of the program. This is discussed in detail in Criterion 2.

Kentucky is approaching its final year of a six-year Comprehensive Community Mental Health Services for Children and their Families grant, referred to as the "Bridges Project." The funds are contracted out to three Appalachian regions that are extremely rural, with high rates of unemployment, poverty, substance abuse and school dropout.

The major goal of the grant is to redesign and enhance a comprehensive system of care for children with SED, and their families, by building on Kentucky IMPACT through increasing the involvement of schools in the service delivery system. Division of Mental Health staff holds key grant management positions, and OFL serves as the family organization contact for the project. Several regions are partnering with other child-serving entities to implement or sustain current implementation of the Bridges model currently supported by CMHS System of Care grant funding which ends in September 2004.

Kentucky has applied for a subsequent CMHS System of Care grant that focuses on serving youth with co-occurring mental health and substance abuse disorders.

Component 4: Systems Interface

REGIONAL PERSPECTIVE

The Regional and Local Interagency Councils represent legislatively mandated partnerships among child serving agencies/parent partners for the purpose of planning and service delivery for children with SED, and their families, but many additional collaborative relationships exist across the state. Many regions provide clinical and consultative services as a result of formal and informal arrangements (verbal agreements, signed Memoranda of Agreement, formal service contracts with in-kind and financial resource sharing). These include partnerships between Regional Boards and local school districts, local child welfare agencies, local health departments and other health providers, early care and education programs, Head Start providers, Child Advocacy Centers (for child sexual abuse victims), juvenile justice, law enforcement, courts and numerous others.

Due to the Regional Boards serving multiple counties, both urban and rural, regional child planners also focus efforts on ensuring continuity of care within their own systems. This includes enhanced collaboration between traditionally separate service systems (e.g., mental health and substance abuse, child and adult services for transitioning age youth), as well as between treatment providers and others within their organizations responsible for data collection/entry and quality assurance.

During the Annual Plan and Budget application process in April 2004, the Regional Boards reported the following Plans for Development, for their respective region. Only one plan per criterion was required, therefore, not all regions chose to address this component within Criterion 1:

Region	Plan for Development for SFY 2005
2	Ensure direct and focused communication among Pennyroyal Center, community providers, and the IMPACT program. Provide IMPACT presentations at staff meetings in each of the four area clinics on a quarterly basis.
6	Improve systems interface internal to Regional Board by increasing communication among all children's supervisors/managers. Hold a minimum of two agency wide forums during SFY 2005. Distribute written information regarding children's procedures and quality information via email twice a year.
14	Develop, maintain, and disseminate information to the community and target population (IMPACT families) at least every six months.
15	Increase referrals for Service Coordination for the mental health system by 5%. Service Coordinators will increase the frequency of attendance at outpatient clinical staff meetings to encourage appropriate referrals. Clinical staff will receive one informational training session concerning referrals for Service Coordination.

STATE PERSPECTIVE

The SIAC is discussed in greater detail in Criterion 3 and serves as a model for collaboration at the state level. There have been many additional ad hoc and sustained multi-partner groups that have existed over the past several years as issues arose that indicated a need for short or long term collaboration. Currently there are two work groups of the SIAC meeting to address co-occurring disorders and brain injury. There also have been work groups to develop Clinical Pathways for Children with Autism, to assist the department in creating a revised Outcomes Measurement System for Kentucky IMPACT, and to gain consensus on a working definition of and related protocols for Emotional Injury.

One partnership that exemplifies a formal, sustained partnership is **IMPACT Plus**. Kentucky implemented IMPACT Plus, a behavioral health program for Medicaid eligible children with complex behavioral healthcare needs, in January 1998, to increase the variety and availability of community-based service options and to decrease the need for inpatient care.

Through IMPACT Plus, Kentucky Medicaid reimburses KDMHMRS and the Department for Community Based Services (DCBS) for Medicaid billable services they purchase. KDMHMRS and DCBS in turn sub-contract with mental health agencies and private mental health professionals across the state to provide a wide network of traditional and innovative behavioral health services.

IMPACT Plus services expand on the Kentucky IMPACT program and traditional Medicaid services to include the following comprehensive array:

- Targeted Case Management;

- Outpatient Services (individual, group, and collateral);
- Therapeutic Child Support Services (behavior modification, mentoring);
- Parent to Parent Support Services;
- Partial Hospitalization;
- Intensive Outpatient Services;
- Mental Health Day Treatment;
- After School and Summer Programs;
- Residential Crisis Stabilization;
- Therapeutic Group Residential Care; and
- Therapeutic Foster Care.

A basic premise of IMPACT Plus is that cost savings realized from decreased rates of hospitalization and other restrictive levels of care would be redirected to support community-based service provision. Management staff from the participating Departments continues to monitor program expenditures and adherence to this "cost neutrality" principle. Currently, identified needs include a continued focus on program reviews and utilization trends using evidenced based practice standards for each service component. Priorities include increased focus on evidenced best practice research, provider training, network capacity, and outcome measurement.

Transition (Youth to Adult) Services
The Department is currently represented on the statewide Kentucky Transition Council for Persons with Disabilities and a subcommittee to address the issue of youth with disabilities who are transitioning to adulthood. The overall mission of the subcommittee is to collaborate with key stakeholders to develop a formalized infrastructure through which students, parents and professionals can:

- Communicate and build local teams;
- Identify current practices and areas in need of improvement;
- Share resources, knowledge and unique experiences and expertise; and
- Benefit from successful outcomes and shared rewards.

The steering committee is comprised of representatives for several state agencies including:
Kentucky Department of Education

- Division of Exceptional Children Service
- Division of Career and Technical Education
- Kentucky Special Education Cooperative Network
- Commission for Children with Special Health Care Needs
- Kentucky Department of Vocational Rehabilitation
- Kentucky Deaf Blind Project
- Interdisciplinary Human Development Institute (University of Kentucky)
- Kentucky Department for Mental Health and Mental Retardation Services

This work is expected to continue into the coming fiscal year and funds will continually be sought to further achieve their goals.

PERFORMANCE INDICATORS

1. Penetration Rate--Children With Severe Emotional Disabilities

Value:	Percent
Measure:	Percentage of the estimated number of children with severe emotional disabilities who are annually served by a Regional Interagency Council or a Regional MH/MR Board.
Numerator:	Unduplicated sum of children served during the SFY by a Regional Interagency Council, and children with an "SED" marker in the KDMHMRS data set who received a Regional MH/MR Board service.
Denominator:	Five percent of the Kentucky child census.

Please see Appendix A for completed reporting tables of the CMHS Performance Indicators in the requested format.

ACTION PLANS

With regard to the component of ***Family Involvement and Support***, several efforts will continue in SFY 2005. Over the past several years, there has been an identified need for Standards of Practice for Family Liaisons. These were drafted by the State Family Advisory Council, with input from a variety of stakeholders including the Regional Boards that employ the Family Liaisons and the State Interagency Council. These standards were adopted by the SIAC and shared statewide.

There is also a workgroup that has given considerable effort to drafting a framework for a Family Involvement Outcomes Measurement System across the state. It is applicable to mental health, mental Retardation and substance abuse service systems for children.

Further piloting, and expansion of specific ones to be used, is underway for the Family Involvement Outcomes Measurement System. There is also great need to offer training and technical assistance to the field but resources are limited. There are potential lessons to be learned and further revisions to the draft document to be completed. With budget constraints and multiple priorities competing for equal attention, it is sometimes a struggle to keep stakeholders at all levels engaged in furthering the Family Involvement initiatives. As time and resources become available, the drafted outcomes measurements will be implemented in different regions of the state and the results analyzed to further develop the instruments and complete the project.

- **State Objective C-1-1:** Utilize Opportunities for Family Leadership to conduct analysis of the piloted Family Involvement Outcomes Project and develop a plan for future statewide implementation.

With regard to the component of ***Clinical Services***, KDMHMRS, along with its partner agencies continues to pursue expansion or increased effectiveness of successful "model" programs, including the Crisis Stabilization Network, the Community Medications Support Program, services for children birth to five years and outpatient services delivered in the community (e.g. client homes, schools, child care facilities, etc.).

The child service system is relatively well-developed and most services are available in all counties of the state or at least within a thirty-mile radius, still there are many areas where improvements are desired. The major priorities for the coming year include:

- Developing further the crisis response and crisis stabilization network;
- Increasing the number of adequately trained and experienced clinicians/consultants to address mental health concerns for very young children (age birth to five years);
- Increasing the number of school-based services available to children;
- Further implementing the web-based CALOCUS assessment tool;
- Collaborating with the Kentucky Transition Council for Persons with Disabilities and its partner agencies;
- Collaborating with partner agencies to share data for collaborative planning;
- Strengthening and seeking additional Memoranda of Agreement with the Department for Public Health, the Kentucky Department of Education and others to enhance utilization of limited resources; and
- Continuing the exchange of information and ideas between the department and the Regional Boards on a variety of issues.

Recommendation 4.2 of the President's New Freedom Commission on Mental Health calls for improving and expanding school mental health programs. This recommendation is mirrored across Kentucky. While all fourteen Regional Boards are implementing some level of school-based mental health services, educators and clinical stall alike still express a desire for growth in this area. In many school districts the availability of mental health professionals is insufficient to meet the need.

All of the Early Childhood Mental Health (ECHMH) Specialists have received training in working with the birth to five population, including the Infancy and Early Childhood Training Course offered annually by Dr. Stanley Greenspan. During SFY 2004, the Specialists and other Regional Board clinicians have received extensive training in early childhood development and mental health from staff of the Comprehensive Assessment and Training Services (CATS) Project at the University of Kentucky. It is hoped that through this and other collaborative training efforts, the capacity for regional clinicians to serve children birth to 5 and their families continue to improve. Additionally, throughout SFY 2004, the Specialists have provided and arranged for over 300 regional training opportunities focused on ECMH issues.

More training in the area of ECMH was identified by nearly all of the Regional Boards in their SFY 05 Plan and Budget applications. In some regions of the state, particularly those in urban areas and those covering a large geographic are, having only one position dedicated to implementing this initiative has been difficult. Increasing the skill level of other Regional Board staff in working with this population would decrease the clinical demands on the Specialists, allowing them to spend more time providing consultation and education services to early care and education programs.

The ECMH initiative will continue to offer Regional Board staff opportunities to receive training in ECMH through their regional ECMH Specialist, as well as through the training provided by the CATS clinic staff.
The CATS clinic staff will offer twelve training opportunities related to ECMH in FY 05. This will be provided through the contract between the CATS clinic and the Department for Public Health. The ECMH Specialists send a monthly report to the DPH ECMH Program Administrator. Additionally the DMH and DPH ECMH Program Administrators query the KDMHMRS client and event data sets on a monthly basis in order to track children served by the program.

Three regions which initially received funding for demonstration projects to address services for transitioning from child to adult services, and several additional regions have developed services that are addressing the needs of transitioning youth. These include:

- Peer support groups for adolescents;
- Independent Living Skills training for 14-21 year olds;
- Vocational planning workshops;
- Life mapping workshops; and
- Consulting with adult case managers to ensure the smooth transition to needed services for youth reaching age eighteen.

Through participation in national, multi-site evaluation activities, Kentucky has and will continue to expand upon the research base regarding children with SED and system of care outcomes it has accumulated over the past thirteen years.

- **State Objective C-1-2:** Share relevant research-based practice literature with Regional Boards to assist them in determining effective service delivery methods for use in their child and family programs.
- **State Objective C-1-3:** Share regional information collected during the 2005 Annual Plan and Budget Application process with regional children's planners to allow them to pool knowledge and resources.
- **State Objective C-1-4:** Assist Regional Boards in implementing crisis stabilization programs through statewide technical assistance meetings to be held a minimum of three times per year.
- **State Objective C-1-5:** Assist Regional Boards in implementing therapeutic foster care programs through statewide technical assistance meetings to be held a minimum of two times per year.
- **State Objective C-1-6:** Provide statewide training and technical assistance to Regional Board staff and local education authorities in implementing components of the three-tiered, strengths-based model, including Wraparound to address mental health needs of children in school settings.

With regard to the component of ***Service Coordination***, there has long been a desire to balance regional autonomy with fidelity to true Wraparound in the Kentucky IMPACT Program. Efforts continue to ensure that program staff and all the stakeholder groups come together on a regular basis to share information about the most current research literature, lessons learned from practice, and optimal resource utilization.

Addressing workforce issues and flat lined/decreased funding faced by the IMPACT programs statewide is also a priority. Although Service Coordination is highly-valued by consumers, the position of Service Coordinator is generally considered entry level and thus is low paying, albeit a very demanding job. Individuals in these positions often move into other positions leaving the Regional Boards to struggle with recruitment and retention for the positions and with the constant need to train and support these individuals.

There is a department-wide work group that has examined the function of case management and the roles of its providers across service delivery arenas. These include case management in mental health (Adult and Child), mental retardation, brain injury, and substance abuse. The group is currently working to refine goals and strategies to address the overarching goal of clearly stating the shared guiding principles and function of raising the status of the service and its providers.

Plans are underway to revise the IMPACT evaluation system to a comprehensive outcomes system that can be used at the local level to assist staff with treatment and program planning. The first step of developing child and

family outcomes, identifying indicators and adoption of measurement tools, has been completed. Eventually, there is a desire to develop program and system level outcomes and indicators.

With regard to the component of ***Systems Interface***, the department serves as a leader among child serving agencies to encourage and support shared vision and collaborative planning. While the IMPACT program is considered highly successful in serving the population of children with SED in Kentucky, there is a need to refine efforts of interfacing with all the child serving agencies in meaningful ways. This includes making sure consumers and families are involved at all levels. It further demands utilizing local lessons learned and studying new techniques touted in the literature to make continued improvements in the sharing of knowledge, philosophies and resources among the agencies.

Bridges utilizes a three-tiered service model of intervention (universal, targeted, and intensive) in the schools. This is the same model used by the Kentucky Center for School Safety and the Kentucky Department of Education in schools participating in the Kentucky Instructional Discipline and Support (KIDS) Initiative. At the state level, these agencies, as well as the Department for Juvenile Justice, the Office of Family Resource and Youth Service Centers, and the Department for Public Health all support the use of this multi-tiered, comprehensive, and integrated model of service delivery.

- **State Objective C-1-7:** Assist Regional Boards in providing state of the art wraparound services to the children and families that they serve by developing Case Management Standards of Care in collaboration with DMHMRS, SIAC partners, Regional Boards, and youth/families.
- **State Objective C-1-8:** Share aggregated KDMHMRS client and event data with partner agencies in an effort to enhance collaborative planning and to maximize limited resources.

Comments from the Mental Health Planning Council meeting on August 19, 2005:

C-1-1: What about outreach to fathers? Are they involved and to what degree?
Response: We seek all caregivers of the children served but perhaps could stress greater outreach to fathers.
Comment: (pg77) I work with an organization where there are lots of grandparents raising grandchildren, make sure they can represent those kids.

C-1-2: Comment: Is there respite for parents of children w/ SED (written in the plan)?
Response: There is no payer source for respite but many regions do offer some respite services.
Comment: Are there children's crisis programs in all regions?
Response: Yes, there is a crisis stabilization program in every region, whether mobile or a bricks and mortar unit.
Comment: Would be good to have both a unit and a mobile response crisis program in every region. We need analysis of how they are doing. Research on how well these systems work. Did we bring a specialist to the state when we started children's crisis (like we did for adults)?
Comment: The response time (3 hours) in my area is not quick enough and treatment foster homes are not always an answer. Calling law enforcement not always a viable option either because then there is talk of getting DCBS involved. Parents need more respite.
Comment: It will be important to have good data to show the utilization and diversion from hospital if the hospital merger goes through.
Response: We are trying to collect utilization data as well as outcomes data.
We have worked with the Center's IT folks to establish coding for crisis program utilization (mobile or unit) and we are using BRS for adults and now for children who use crisis services.
Comment: Think that there is a need for urgency. We need data to show that funds should be diverted to CSUs as well as a new hospital if the proposal to sell the two state hospitals and build one new one goes through. There will be money from the sale of the two current hospitals.

C-1-3: Comment: Case management services need more funding.

Criterion 2: Children's Mental Health System Data Epidemiology

The plan reports an estimate of incidence and prevalence of SED among children and provides for quantitative service targets to be achieved through the implementation of the mental health system of care as described in Criterion 1.

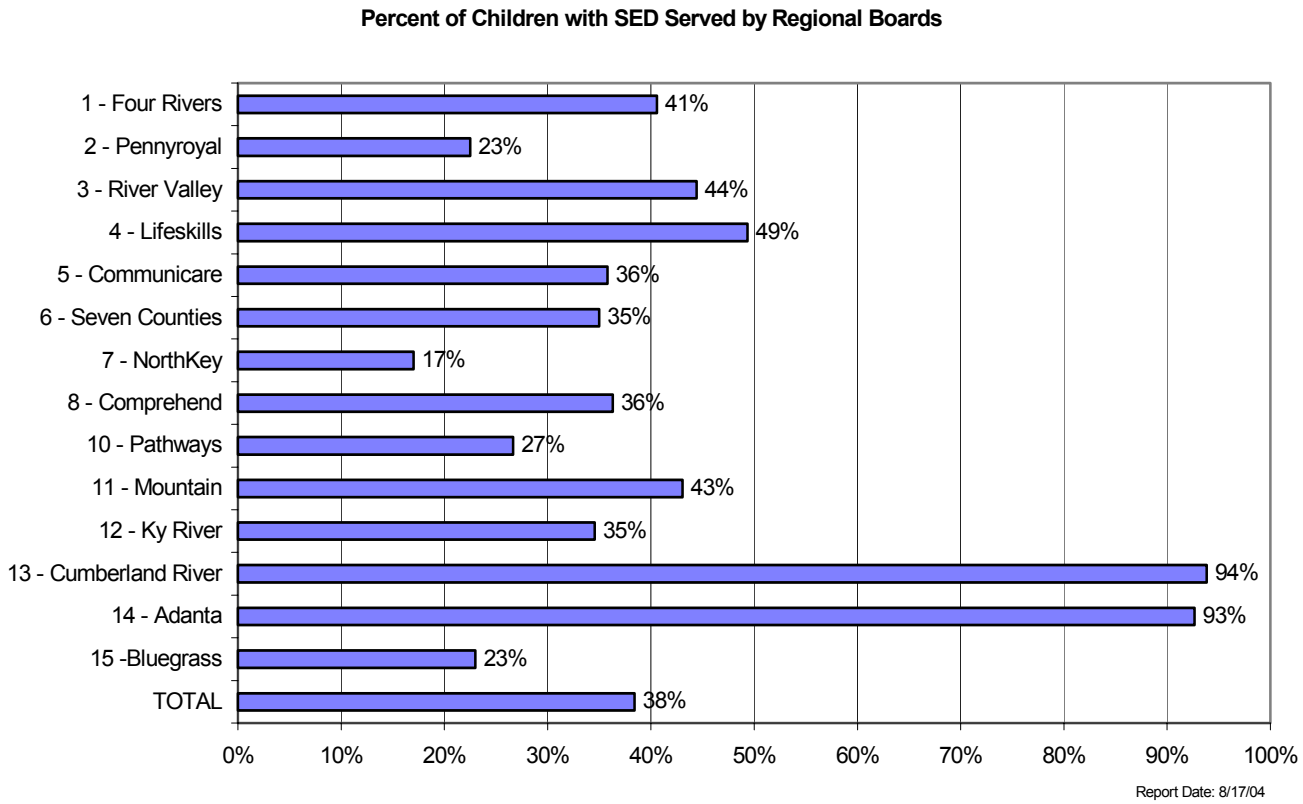
GOAL: To increase access to services for children with severe emotional disabilities.

INTRODUCTION

Using 2000 census data and the state's agreed upon prevalence rate estimate of five percent, Regional Boards are aware of the number of children in potential need of services. However, they rely more heavily on indicators and recommendations from the local communities, parent networks and Regional Planning Councils. *Kentucky Kids Count,* the annual report distributed by Kentucky Youth Advocates is also helpful for program planning. (Contact site is www.kyyouth.org.)

The chart below displays the child population for each region and the estimated number of children with SED.

Regional MH/MR Boards	Child Census 2000	Estimated Number of Children with SED (5%)	Kentucky SED Children Served	Penetration Rate
Four Rivers	45,789	2,289	929	41%
Pennyroyal	51,354	2,568	578	23%
River Valley	52,376	2,619	1,163	44%
Lifeskills	62,142	3,107	1,533	49%
Communicare	65,398	3,270	1,171	36%
Seven Counties	215,082	10,755	3,765	35%
NorthKey	105,280	5,264	896	17%
Comprehend	13,777	689	250	36%
Pathways	49,290	2,465	657	27%
Mountain	39,056	1,953	841	43%
Kentucky River	29,455	1,473	509	35%
Cumberland River	60,398	3,020	2,834	94%
Adanta	46,300	2,315	2,145	93%
Bluegrass	159,121	7,956	1,830	23%
TOTAL	**994,818**	**49,743**	**19,101**	**38%**



REGIONAL PERSPECTIVE

Based on the wide variation of regional penetration rates as charted in Appendix A, it is evident that the SED marker in the KDMHMRS data set is not consistently applied. Accuracy in coding is addressed during the Department's on-site monitoring of Regional Boards, and statistical indicators that rely on the number of children with an SED marker are increasingly used to assess performance and outcomes. Thus, Regional Boards and the Department are increasingly interested in the consistent and accurate use of the marker in the data sets.

A Regional Interagency Council (RIAC) also identifies a child as having a severe emotional disability when admitted to the Kentucky IMPACT program. In addition to taking into account the diagnosis, duration, and severity of the child's disability, RIACs also consider local priorities for service, service availability, and the child's appropriateness for IMPACT services.

In Kentucky, criteria for determining whether a child has a severe emotional disability were included in the enabling legislation (KRS 200.503) for the Kentucky IMPACT program in 1990. These criteria include the following. A child who:

1) Is under age 18 or under age 21 and was receiving mental health services prior to age 18 and the services must be continued for therapeutic benefit; and
2) Has a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that is listed in the current edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders; and presents substantial limitations which have persisted for at least one Year, or are judged by a mental health professional to be at high risk of continuing for one year without professional intervention in at least two of these five areas:
    - Self Care
    - Interpersonal Relationships
    - Family Life
    - Self-Direction
    - Education

Or

- Is a Kentucky resident and is receiving residential treatment for an emotional disability through the interstate compact; or

- Has been removed from the home by the Department for Community Based Services (Kentucky's child welfare agency) and has been unable to be maintained in a stable setting due to a behavioral or emotional disability.

Using the eligibility criteria as defined above, a child served by one of Kentucky's Regional Boards may be identified as having a severe emotional disability by the clinician who serves the child based on a combination of the child's diagnosis and the duration and severity of the child's disability. Regional Board staff places a marker in the child's file and transmits it to the KDMHMRS data system. This process accounts for the majority of children in Kentucky who are identified by KDMHMRS as having a severe emotional disability.

During the annual Plan and Budget application process in April 2004, the Regional Boards reported the following in their respective region.

Region	Plan for Development for SFY 2005
1	Attain a 46% penetration rate for the SED population. Provide $300.00 training allotment to aid in the retention of Service Coordinators, thereby reducing the likelihood of staff turnover.
2	Increase the penetration rate for children with SED by 2%. Increase allocation of Children's Services staff members by one half FTE. Increase referrals to IMPACT by increasing awareness of clinical staff members of the availability of this resource.
3	Training: Train business office staff on priority populations
4	Provide early intervention to children age birth to 5. Provide training to staff in assessment and treatment for children age birth to 5. Early Intervention Specialist will visit 90% of daycares to observe and provide training.
5	To increase the number of consumers with SED served to 35% of estimated target population by June 30, 2005. To provide additional education to professional staff and perform chart reviews on a quarterly basis to check on the marking target populations. To develop and implement after school programs targeted toward serving children with SED who may or may not be in the CMHC system of care.
6	Given flat budgets, maintain the current penetration rates for SED children. Monitor penetration rates quarterly. Each children's service site is to focus on SED coding as part of Utilization Review.
7	Increase overall penetration rate for children with SED from 19% to 25%. Outpatient clinical staff will review their caseloads twice yearly to check that the appropriate SED marker is indicated for all clients. Hire two additional Service Coordinators this fiscal year.
8	Maintain the current rate of SED penetration. Process all IMPACT referrals in a timely manner with presentation to RIAC occurring within 60 days of receipt. Complete a self-analysis regarding the expansion of the IMPACT program to a fifth Service Coordinator position.
9/10	Expand knowledge of coding children with SED. Review coding methods with MIS department. Survey children's staff regarding identifying SED.
11	Increase Department for Juvenile Justice (DJJ) referrals from 1.9% to 2.5%. Utilize the new event data set/client system technology which will accurately match JCIC standardized coding. Meet with DJJ staff to provide information regarding agency services, including mental health and substance abuse services, thereby, bridging the gap between released from juvenile detention and returning to community services.
12	All staff will receive updated training in capturing SED data within the system. Develop an updated written procedure in the process of capturing SED data. Train staff on updated procedures and distribute the written procedure.
13	Continue to strive to obtain all children who qualify for the SED priority population to be marked at admission, status change and at yearly update. Review current number in SED status. Send out reminders to clinical staff regarding criteria for SED and importance of marking priority populations.
14	Provide at least ten (10) contacts during the year with regional DJJ staff. Increase outreach to local DJJ regarding situations where children may benefit from collaborative efforts through personal contact from Local Resource Coordinator as indicated by DJJ RIAC representative. Provide educational opportunities regarding the services of the IMPACT program for DJJ workers in each county or service area of the region.
15	Attempt to maintain trend of increasing penetration despite regressive state funding trends. Staff will appropriately utilize SED marker in admission data set. Penetration rate will be closely monitored throughout the year and determinations will be made as to what reasonable steps can be taken to ameliorate any reversal in trend.

STATE PERSPECTIVE

Kentucky mental health planners have historically used a five percent prevalence rate estimate for severe emotional disabilities among Kentucky children. Using this rate with 2000 census data, there are approximately 50,000 children with a severe emotional disability among Kentucky's 995,000 children.

Kentucky's estimated prevalence rate falls in the low range of estimates derived from local studies and cited in "Prevalence of Serious Emotional Disturbance in Children and Adolescence" (Friedman et. al, SAMHSA, 1996). This study acknowledges the lack of epidemiological data and concludes that regardless of the estimated prevalence rate that may be used, children with severe emotional disabilities are greatly under-served, a conclusion Kentucky planners share.

When a child is identified through either process, a marker is placed in the KDMHMRS data system that identifies the child as having a severe emotional disability. Data concerning services received by children with a marker may then be compiled and analyzed.

KDMHMRS contracts with the Research and Data Management Center (RDMC) at the University of Kentucky to manage the bulk of data it collects. Their data elements include a client demographic data set, a service event data set and a human resources data set. There is also an Adult Outcomes data set that is being established.

To date the IMPACT evaluation system has been housed within the Children and Youth Services Branch of the Division of Mental Health and was not linked with the above-mentioned system. The PC-based systems, developed in 1990, to support the processing and interpretation of Kentucky IMPACT data have proven durable and useful over time. However, as the program has grown in size and there is greater need for integrating and sharing data with regional providers and decision-makers, the goal is to move this evaluation/outcomes system into the larger RMDC managed system. These changes are being made in coordination with the major changes underway for the Department's overall management information system.

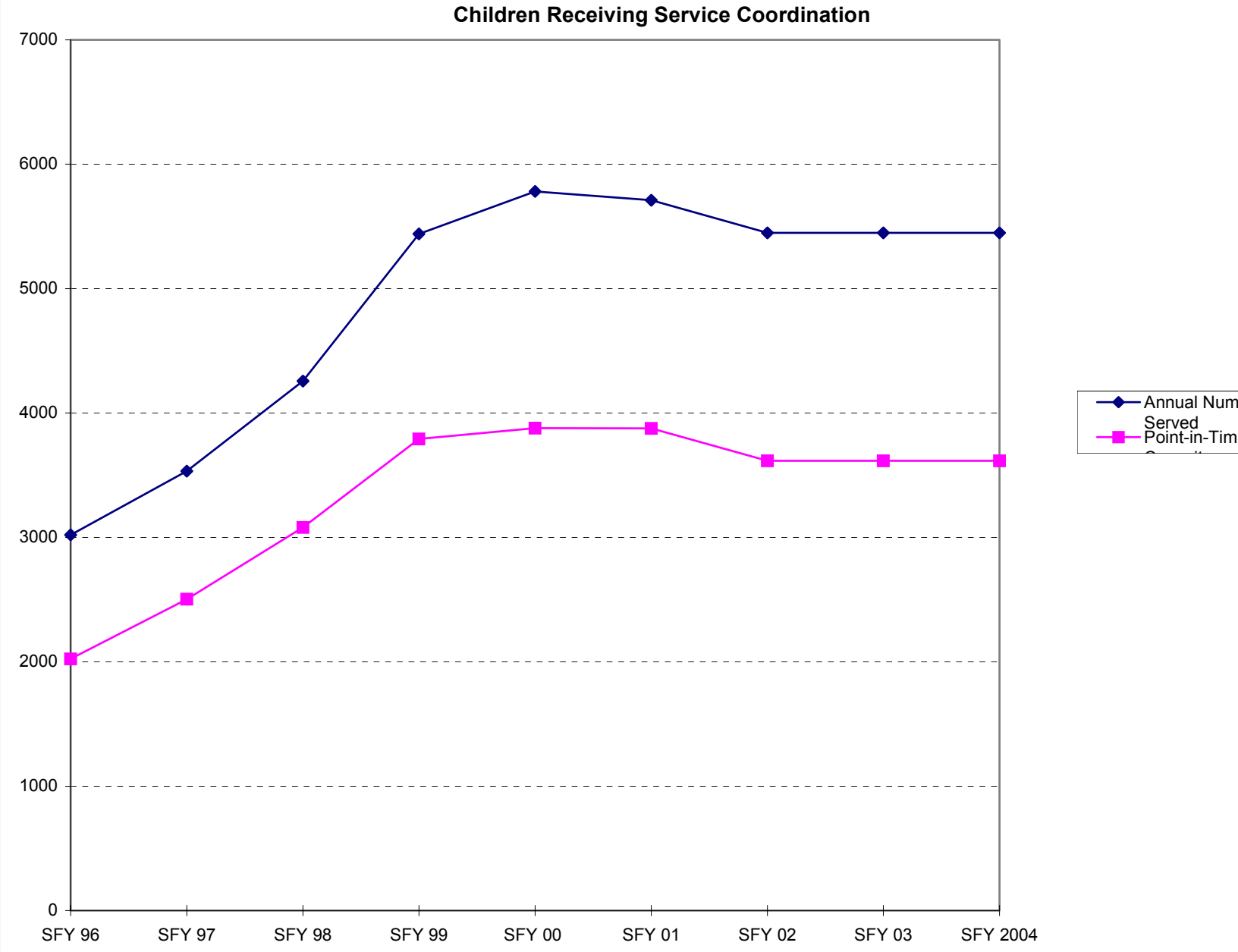
PERFORMANCE INDICATORS

1. Penetration Rate--Children with Severe Emotional Disabilities

Value:	Percent
Measure:	Percentage of the estimated number of children with severe emotional disabilities who are annually served by a Regional Interagency Council or a Regional MH/MR Board.
Numerator:	Unduplicated sum of children served during the SFY by a Regional Interagency Council, and children with an "SED" marker in the KDMHMRS data set who received a Regional MH/MR Board service.
Denominator:	Five percent of the Kentucky child census.

ACTION PLANS

As described in Criterion 1, Service Coordination is a targeted case management service provided to children with SED, normally under the auspices of a RIAC. Targeted Case Management is reimbursable to Regional Boards by Kentucky Medicaid and KDMHMRS, and is the core service of Kentucky IMPACT. The following chart reflects the growth in Service Coordination over the past decade.



The research literature indicates that targeted case management services for children and families, utilizing Wraparound and individualized service plans developed by a team including parents as expert participants, lead to optimal outcomes. Flexible funding is a desirable component of the service model and more is needed to meaningfully increase capacity in Kentucky.

The number of children and families served by IMPACT in SFY 2003 was 5540 which is slightly above the prior year total but down slightly from the two years prior to that. There is a desire to increase capacity in this area of service delivery but there are several variables that must work in unison for this to be accomplished. Staffing issues is among the most salient.

Regional Boards have developed various services to meet the needs of the community and individual children and families that they serve. Many outpatient offices offer services during late afternoon and evening hours. This will keep children who may already be struggling in school from missing instruction in order to receive therapy services. Many clinicians also provide off-site therapy to eliminate barriers such as transportation, childcare for siblings, missed work by parents, etc. Regional Board clinicians also offer more services at school, in after school daycare centers, homes, or in other community settings.

Planners believe that by offering such flexibility in service provision results in a greater number of children and youth receiving needed services. This also moves us toward the goal of reaching children before problems are

exacerbated or escalate to crisis. A continual challenge is in the funding of services off-site. The additional costs associated with travel and off-site logistics is sometimes problematic.

In August 2002, management of the Kentucky IMPACT data evaluation system shifted from the Division of Mental Health to a collaborative venture with State Interagency Council (SIAC) staff serving as the lead. A state level steering committee comprised of SIAC and Division staff is working closely with a workgroup of key stakeholders. Their goals are to:

- Evaluate the type of data needed to measure the program's effectiveness considering child and family indicators/outcomes; and
- Identify how best to manage the data so that it can be returned in a timely manner to the regional staff (Service Coordinators and IMPACT program managers) for treatment planning. It is also anticipated that aggregate data will be valuable to those making regional and state level policies that are responsive to programmatic trends.

As noted in Criterion 1, Regional Interagency Councils may approve the use of flexible, discretionary funds (wraparound expense) for IMPACT clients when there is no other payer source. KDMHMRS continues to process Wraparound Expense data, detailing expense by child and by service category. This information is submitted monthly by the regional IMPACT Programs and the Regional Boards to KDMHMRS. With the exception of one region, expense data are submitted via hard copy to KDMHMRS for processing, a time consuming and potentially error-prone process for regional and KDMHMRS staff. Although it will take some time to accomplish, it is desirable to create the ability for all regional programs to electronically submit this information.

- **State Objective C-2-1:** Ensure that children with SED are accurately reflected in the KDMHMRS data system through continued analysis of the data received, technical assistance to Regional Board staff, and on-site monitoring.
- **State Objective C-2-2**: Develop a plan for implementing the newly revised Kentucky IMPACT Outcomes Measurement System.

Comments from the Mental Health Planning Council meeting on August 19, 2005:

There were no comments for this Criterion.

Criterion 3: Integrated Children's Services

A statewide system of integrated services will be provided so children with severe emotional disabilities (SED) will receive care appropriate to their multiple needs. Ongoing efforts are targeted at integration of social services, educational services (including services provided under the Individuals Disabilities Education Act), juvenile justice services, substance abuse services, and health and mental health services. Defined geographic areas for the provision of the services of such a system are established.

GOAL: To ensure that services for children with severe emotional disabilities are fully integrated and holistic.

INTRODUCTION

An integrated service system for the children and families served by Regional Boards is stronger in some areas of the state than in others. Examples of truly integrated services are sometimes found in very small communities where professionals and community members are well acquainted and have a long history of working together to achieve commonly held goals for their service recipients. Often where resources are the scarcest, creativity is strongest. Larger communities, while generally having the advantage of more resources, may face greater challenges in coordinating their efforts. Human Services Council meetings in many urban and rural counties serve as a monthly opportunity to share agency information and exchange referrals. In addition, there are numerous other networking and case conferencing mechanisms in place at the local level to encourage and support general agency and client specific information exchange and collaborative planning.

Partners learning the details of each others' specific job roles and their designated service areas is generally a beneficial starting place for assuring that children and families are served in the most effective and least restrictive manner. Most agencies do have specified service areas but adjustments are sometimes made to accommodate special circumstances. Child welfare and community mental health have very similar service areas but the courts/ juvenile justice and special education cooperatives are quite different from the community mental health region configurations.

REGIONAL PERSPECTIVE

The interagency structure of Kentucky IMPACT drills down to the level of the child's service team. When a child is admitted to Kentucky IMPACT, a Service Coordinator is assigned to convene an interagency service team. The team consists of the child (when appropriate), his parent(s), his teacher(s), and other involved parties who work with the child and his family. A Regional Board is also the substance abuse and mental retardation planning authorities for its region, so those services may be accessed by the Regional Interagency Councils (RIAC) through the Board's representation on the RIAC.

The Service Coordinator facilitates the team meeting in developing an interagency service plan that focuses the efforts of each member of the team on the desired outcomes for the child. The plan does not replace educational or treatment plans, including plans for educational services under IDEA, but coordinates and focuses them. The plan also identifies areas where Wraparound services may be utilized to fill service gaps.

A Local Resource Coordinator (LRC) supports each RIAC, often supervises a team of Service Coordinators, and develops local resources that can be accessed by service teams for children with SED, and their families. KDMHMRS and Kentucky Medicaid reimbursements for Targeted Case Management services help fund these staff positions. Criterion 1 and 2 provide considerable information about the delivery of Service Coordination and Wraparound, the primary services of Kentucky IMPACT.

Training in the difficult role of facilitator is provided to Service Coordinators through certification training, which is conducted by interagency trainers. The training is reinforced and supplemented through workshops and peer meetings at statewide collaborative conferences for IMPACT staff and RIAC members.

Twelve of fourteen regions report that Service Coordination services are offered to youth transitioning into adulthood, many of whom are linked with mental health services, as well as other independent living related services. Several regions also offered specialized services for this population (e.g., independent living skills training, peer support opportunities).

During the Annual Plan and Budget application process in April 2004, Regional Boards reported the following in their respective region.

Region	Plan for Development for SFY 2005
1	Provide advanced training to clinical practitioners on co-occurring issues (MH/substance abuse and MH/mental retardation)
2	Integrate all Children's Services in the same location for children in Christian county. Relocate First Steps Office and Early Childhood MH Office to main campus.
3	Physical Health: Complete physical history on all new clients. Refer clients to appropriate physician.
4	Increase services to clients with co-occurring disorders. Provide training on identification and treatment of co-occurring disorders and specifically client centered approaches.
5	Increase the total number of referrals for MH services at point of entry (birth0 3 aged children with or without developmental delay, by 6-30-05. Complete integration of First Steps services into MH Children's Services. Provide in-service training to Service Coordinators regarding MH services.
6	Increase number of youth assessed by the Global Assessment of Individual Needs (GAIN) to ensure a holistic assessment across domains. Track children assessed at 6 and 12 months. Increase number of GAINs completed by other LANSAT (substance abuse program) providers.
7	Initiate grant with DJJ entitled "Building Family and Community Resources" and serve projected number of youth in year one. Two Functional Family Therapy (FFT) staff will be identified and receive required FFT training, and develop criteria with forms for utilization in the program. One half of projected number of clients will start the program with 75% completing the identified three (3) phases of treatment.
8	Cross train school-based clinicians on substance abuse prevention, assessment and pretreatment skills for use as part of the school-based program for substance abusing children. Formulate a plan for training at least 6 staff on basic prevention, assessment and pre-treatment services. Complete a grant application to the Greater Cincinnati Health Foundation on Adolescent Substance Abuse services to include Functional Family Therapy and an Intensive Outpatient program.
9/10	Enhance collaboration with other agencies. Attend local continuity of care meetings.
11	Conduct at least one meeting with each of the Health Departments in the region. Share information about services that are available through public health and discuss services available through community mental health. Strategize ways in which to utilize the expertise of other agencies in providing services to mutual and future clients.
12	Explore implementation of an assessment tool that will assist in better identification of the bio-psycho-social needs of a child/youth. Explore existing assessment tools and choose a tool to be implemented. Pilot the implementation of the assessment tool as the bio-psycho-social assessment in at least one county.
13	Develop a structured format to assess, plan, develop treatment goals/care and evaluations of physical and MH needs with a special emphasis on childhood obesity and physical fitness and mental well being. Evaluation of current assessment tools which identify physical and mental health needs. Develop or add to current assessment tools a structured format to address physical health issues that are related to child's mental health, by December 2004. Present a completed structured format to medical records for review and approval by February 2005.
14	Cross train clinical staff in non-primary focuses of clinical training. Cross train at least 5 Service Coordinators in Early Childhood issues and strategies. Provide access to all children in each county one professionally trained substance abuse/mental health professional for consultation, assessment and treatment recommendations.
15	A training on early childhood mental health/behavioral disorders will be delivered to primary care providers. Training curriculum will be developed and training package will be delivered at one pilot site.

STATE PERSPECTIVE

In Kentucky, the system of care for children, including those with severe emotional disabilities strives to provide services utilizing Wraparound. This strategy relies on a foundation of policy makers and service providers that take into account all of the goals and day to day activities of the child when assessing the needs of the child and his or her family.

KDMHMRS continues to promote activities that build the infrastructure for coordinated and optimally integrated services for children with SED, and their families. Model examples of collaborative efforts found in the regions are often shared with others through technical assistance by the department. As discussed in Criterion 1, the State Interagency Council for Services to Children with an Emotional Disability (SIAC) is a group of representatives, from the primary child-serving agencies, and a parent of a child with an emotional disability, who maintain and oversee a

framework of collaborative services for children with emotional disabilities. The hallmark program of this framework is Kentucky IMPACT, but other programs and initiatives may also fall under their auspices. The table below illustrates the composition of the SIAC and RIACs. Some RIACs have also developed Local Interagency Councils (LIACs) at the county level to mirror the composition of the SIAC and RIACs, but to enhance the ability to develop resources at the local level and to problem solve when systemic issues may arise. The Chair of SIAC alternates each year but the Chair for RIACs is legislatively mandated as the DCBS representative.

Composition of IMPACT Interagency Councils

SIAC Representative	Domain	RIAC Representative
Parent of a child with a severe emotional disability	Family Members	Parent of a child with a severe emotional disability
Commissioner, KDMHMRS	Mental Health	Director of Children's Services, Regional MH/MR Board
Commissioner, Department for Community-Based Services	Child Welfare	Service Region Administrator, Department for Community-Based Services
Commissioner, Department of Public Health	Public Health	Representative, County Health Department
Commissioner, Department for Medicaid Services	Medicaid	Not represented
Commissioner, Department for Juvenile Justice	Juvenile Justice	Regional Program Manager Department for Juvenile Justice
Executive Director, Dependent Children's Services within Administrative Office of the Courts	Courts	Court Designated Worker selected by local district judges
Executive Director, Family Resource and Youth Services Centers	Prevention and Early Intervention	Not currently required but may be added at the discretion of the RIAC
Commissioner's Designee, Department of Education	Education	Special Education Specialist, Local Education Authority

With a charge from the SIAC, a **Traumatic/Acquired Brain Injury Workgroup** has met regularly to study service delivery and supports for community living issues involved for children and transitioning youth with dual or multiple diagnoses of mental health, mental retardation, and traumatic brain injury. Representatives from several child and adult serving agencies participate as stakeholders on this group. With a similar charge from SIAC, the **Co-Occurring Workgroup** has been convened to focus on children within the Juvenile Justice system who are deemed in need of mental health and substance abuse assessment and treatment.

The Autism Spectrum Disorder Advisory Consortium (ASDAC), formed in March 2002 with representatives from the KDMHMRS, Regional Boards, KDE, the Kentucky Autism Training Center (Department of Education/University of Louisville), DCBS, and parents of children with Autism. Originally there was a workgroup that developed a "Clinical Pathways for Children with Autism" document intended to be a description of how families can access appropriate evaluations and services available in Kentucky through universities, health care providers and educational services. The Consortium continues to serve as an expert advisory body regarding services and supports to children with Autism Spectrum Disorder and their families in Kentucky.

Public Health

Staff from the Department for Public Health and KDMHMRS meets regularly as they share oversight of the Early Childhood Mental Health Initiative and the designated Specialists. There is also shared oversight of the Bioterrorism Preparedness program. Most recently, the sharing of aggregated data between the two departments has occurred and there are plans to continue these efforts in various ways, including the sharing of hospital data previously unavailable to mental health.

Education

KDMHMRS staff collaborates extensively with state and local educational agencies in support of IDEA and other initiatives focused on simplifying access to and coordinating services for children and youth with emotional and behavioral needs. One such other initiative involves the department's technical assistance to the Kentucky Department of Education (KDE) to integrate a mental health and family component in the implementation of their

Instructional Discipline Pilot Program (IDPP). This program is based on a three-tiered prevention model, using Positive Behavior Interventions and Supports (PBIS). The PBIS model encourages the involvement of mental health staff and parents at all levels of intervention and support (universal/primary, targeted/secondary, and intensive/tertiary). In addition to the provision of technical assistance in programming, a staff member from the department spends .25FTE designing and coordinating the evaluation of the Instructional Discipline Pilot Program and providing evaluative results for purposes of decision support around programming, practice refinement, and policy.

Another strong collaborative between KDMHMRS and KDE is a Memorandum of Agreement (MOA) which provides for sharing of resources and joint training for children's mental health and children's public educational services. The focus of the SFY 2004 MOA between the SIAC and the Department for Education was two-fold: To expand school mental health service delivery expansion and to enhance collaboration between education and mental health on the state and local level. On-going training and technical assistance regarding Wraparound, school-based mental health services, as well as the annual Choices and Changes Collaborative Conference are supported by the MOA. These efforts will continue in for SFY 2005 and there is an added item to ensure collaborative support for the work Transition subcommittee discussed in Criterion 1.

Chaired by the Division of Exceptional Children within KDE, the **Kentucky Interagency Transition Council for Persons with Disabilities** is made up of nine state agencies, including KDMHMRS. Their mission is to facilitate the work of state, regional and local agencies as they assist young persons with disabilities (all types) in moving from school to community living and employment.
The **Kentucky Educational Collaborative for State Agency Children** (KECSAC) was established through legislation in 1992. KECSAC Advisory Group members include representatives from six agencies, including KDMHMRS. KECSAC is the responsible entity for assuring that the benefits of the Kentucky Education Reform Act (KERA) are extended to children in the custody of state agencies, in day treatment programs, and schools on the campuses of residential programs.

A cadre of individuals representing various child-serving agencies that assembled in 1999 to form the **Kentucky School Mental Health Coalition**. The Coalition membership includes representation from the following:

- KDMHMRS (Division of Mental Health and Substance Abuse)
- Department of Education
- Department of Juvenile Justice
- Center for School Safety
- Kentucky Educational Collaborative for State Agency Children
- Regional MH/MR Boards
- Kentucky Psychological Association
- University of Kentucky School of Nursing
- University of Kentucky Chandler Medical Center
- Health and Welfare Committee of the Legislative Research Commission
- Department for Public Health
- Cabinet for Families and Children
- Kentucky School Board Association
- Kentucky Academy of Pediatrics
- Private Child Care

Acknowledging the need to improve and expand mental health services traditionally offered in schools, the Coalition has as its mission the expansion of school mental health services across the Commonwealth.

Child Welfare
The Department for Community Based Services (DCBS) is now within the same Cabinet as KDMHMRS and Public Health so the opportunities for data sharing and collaborative planning may become easier as we work together towards common goals. There are currently activities underway to bring together the Children's Services Directors from the Regional Boards and the Service Area Administrators from the DCBS regions to discuss issues of mutual interest including emotional injury, case consultation and transitional planning.

Juvenile Justice
Juvenile Justice's new system of care has been extremely beneficial to a group of children whose needs are very complex, but there is a growing interest in reaching children at earlier stages of their involvement with the child welfare and juvenile justice systems. In particular, the Department for Juvenile Justice (DJJ) has reached out to

contract directly with Regional Boards and Private Child Care Agencies for community-based services and juvenile sexual offender treatment. However, DJJ has also begun creating positions within of their own agency to provide mental health and substance abuse services for their especially difficult to serve youth (e.g., adolescent sex offenders). The rise in the number of youth committed to Juvenile Justice and the historic lack of comprehensive mental health services to children and youth in the juvenile justice system make this desire for earlier intervention even more urgent.

State-level work groups were established to review regional planning council reports and recommend state-level initiatives to the HB 843 Commission (discussed in greater detail in Section II of this document). The Children's work group, focusing on children's services and service gaps, consists of the State Interagency Council as its core membership and is staffed by the Director of the SIAC staff within the Division of Mental Health and Substance Abuse.

KDMHMRS and DJJ are also working together to compare the data each has and determine if there are assessment and outcomes measurement tools that might be shared. A portion of block grant dollars may be utilized for the Bristol Observatory to assist with some data analysis.

PERFORMANCE INDICATORS

1. School Attendance

   Value: Percent

   Measure: Percentage of children with SED who are attending school regularly during the year.

   Numerator: The total number of children in the IMPACT program who are attending school greater than 90 percent during the year as reported on the Educational Status Checklist, completed by the teacher.

   Denominator: The total number of children and who are served by IMPACT during the year for whom the Education Status Checklist was completed by the teacher.

2. Outreach - Juvenile Justice Referrals

   Value: Percent

   Measure: Percentage of children with SED served by Regional MH/MR Boards who were referred from the justice system.

   Numerator: Number of children with SED markers served by Regional MH/MR Boards who have a Source of Referral status of:
   - Police
   - State or Federal Court
   - Formal adjudication processes other than state or federal court
   - Probation and Parole
   - Recognized legal entity other than probation and parole
   - DUI/DWI
   - Other criminal justice
   - Diversionary program &
   - Department Juvenile Justice

   Denominator: Number of children with SED markers served by Regional MH/MR Boards.

ACTION PLANS

True collaborative planning and sharing of resources is difficult at best, but with the commitment Kentucky has experienced since the inception of the Kentucky IMPACT program and the creation of the SIAC, it has become a reality at the state, regional and local level. Constant nurturing of the relationships and the resulting creativity is what has made it successful in benefiting the children and families of Kentucky. Entering into formal Memoranda of Agreement has proven very valuable as well. Just like a written service plan with goals and objectives where all

team members take on tasks to achieve mutual goals for the child and family, so it works for stakeholders working towards mutual goals.
Successes of Youth Transitioning to Adulthood services initiatives include the involvement of the adult services community with transition-age adolescents, reduced caseloads for Service Coordinators serving this population (which allows them to focus on transition issues), and improved collaboration with the school-to-work programs implemented as a part of the Kentucky Education Reform Act. KDMHMRS is currently optimistic that regional transition councils will be created and that this will further the collaborative manner in which services and supports are made available for transitioning youth across Kentucky.

- **State Objective C-3-1:** Further develop partnerships between mental health and the Kentucky Interagency Council for Persons with Disabilities and the Kentucky Transition Project at the University of Kentucky's Interdisciplinary Human Development Institute to address transition issues of youth with SED.

Comments from the Mental Health Planning Council meeting on August 19, 2005:
There were no comments for this Criterion.

Criterion 4: Targeted Services to Homeless and Rural Populations

The plan provides for the establishment and implementation of outreach to and services for, such individuals who are homeless. The plan also describes the manner in which mental health services will be provided to individuals residing in rural areas.

GOAL: To improve services capacity to persons who are homeless or who reside in rural areas of the state.

INTRODUCTION

Under this criterion, services provided by Regional Boards to children with SED, who are homeless or who reside in rural counties (within regions) of the state will be addressed. Thus, current activities regarding each of the two components Homelessness and Rural are discussed below, offering detail from a regional and state perspective. Related goals and action plans for the components are discussed collectively at the end of Criterion 4.

Component 1: Homelessness

REGIONAL PERSPECTIVE

Many Regional Boards do not continuously identify the living arrangement status of all children served and efforts remain ongoing to improve tracking of this. However, there are Regional Boards that have services targeting homeless or near homeless youth. The outcomes measurement system of the children served in the Kentucky IMPACT program are tracking living arrangement of those children. Five of the fourteen Regional Boards have specialized case management services for homeless youth. There are agreed upon protocol and priority referral policies in several regions. These are primarily relationships between Regional Boards and homeless shelters or other programs that specifically serve women and children who may be homeless or at risk of homelessness (e.g., children aging out of foster care, families seeking to escape domestic violence situations).

During the Annual Plan and Budget application process in April 2004, Regional Boards reported the following in their respective region.

Region	Plan for Development for SFY 2005
6	Coordinate with local coalitions to address mental health needs of homeless populations. Meet with staff of Host House to assess ways that the Board can help with Mental Health needs. Meet with Bullitt County Homeless Coalition to assess need for interventions with homeless families.
9/10	Increase refinement of coding “homeless” and review method for collecting data with MIS.
11	Administer a needs assessment to determine if there are homeless youth and what services may be of benefit to those individuals. Determine format for needs assessment and who will participate in the needs assessment.
13	School-based clinicians and Service Coordinators will routinely make home visits on high risk children as needed and in emergency situations utilizing the wraparound process. Establish a list of high risk children and schedule home visits. Documentation of home visits will be submitted to supervisors for clinical supervision
15	Special planning processes will be implemented when a homeless youth is identified. The Regional Children’s Services Coordinator will oversee planning for any identified homeless youth in need of services. All services planning will include goals and methods targeted at stabilizing the living situation of the identified youth.

STATE PERSPECTIVE

Estimates are that 12,467 persons are homeless each day in Kentucky. According to the 2001 Homeless Survey conducted by Morehead State University, the most common rural homeless is a single woman, age 35, with two children. She has a high school education but did not graduate. She is Caucasian and most often a victim of domestic violence. It is important to have an understanding not only of those homeless on any given day, but those who are “at-risk” of becoming homeless. The Kentucky Council on Homeless Policy has decided to focus their efforts on prevention as a key to reducing the number of people who will experience homelessness in Kentucky and are currently in the process of developing and implementing a statewide prevention plan.

Component 2: Rural

REGIONAL PERSPECTIVE

Using the definition of Standard Metropolitan Statistical Area, and information from the 2000 Census, Kentucky has 35 counties considered urban and 85 considered rural. Approximately 44% of the state's population resides in its 85 rural counties.

Estimated Children with SED residing in service area of an MHMR Regional Board				
Region	Urban		Rural	
	2000 Census Child	5% of Child Pop	2000 Census Child	5% of Child Pop
01	0	0	45,789	2,289
02	23,345	1,167	28,009	1,400
03	42,715	2,136	9,661	483
04	24,143	1,207	37,999	1,900
05	47,522	2,376	17,876	894
06	215,082	10,754	0	0
07	100,016	5,001	5,264	263
08	2,115	106	11,662	583
10	19,539	977	29,751	1,488
11	0	0	39,056	1,953
12	0	0	29,455	1,473
13	0	0	60,398	3,020
14	0	0	46,300	2,315
15	93,475	4,674	65,646	3,282
Total	567,952	28,398	426,866	21,343

Rural communities often have fewer staff and resources to provide mental health services. It is important for rural mental health agencies to develop collaborative agreements with primary care physicians, senior citizens, church groups, and government agencies. Rural case managers have been resourceful in assisting persons with a severe mental illness in identifying their needs, as well as meeting these needs through the identification and development of local resources, and are critical linkages to formal and informal services and supports in rural Kentucky. Several actions by the Kentucky General Assembly have increased the types and numbers of mental health professionals who can be Qualified Mental Health Professionals and created licensure for mental health counselors. The KDMHMRS will continue to work with rural communities and other entities in these activities including addressing shared federal, state, and local funding, shared and cross training, and bringing all stakeholders together at the state and local level to strategize best practices.

During the Annual Plan and Budget application process in April 2004, Regional Boards reported the following in their respective region.

Region	Plan for Development for SFY 2005
1	Provide enhanced rural transportation services to the Partial Hospitalization Program. Establish two rural pick up and drop off locations for children and youth attending the program. Develop one additional transportation resource for rural children and youth attending the program.
2	Submit written plan for Executive Director approval and begin pilot program for providing therapy services to children with SED at the schools they attend in four of the most rural counties of the region. Devote approximately 2 FTEs of therapists' time to the in-school program. After first year, evaluate success and redesign or augment the program as necessary. Negotiate agreements with local school districts to include all necessary exchange of information, identification and presentation of students, space, and staff utilization and program evaluation.
3	Review feasibility of telehealth and increase in-home services in rural counties.

5	Increase rural penetration rate to 35% by modifying the internal process to ensure that all appropriate cases are captured in the priority population. Amend the psychosocial intake form and treatment plan to include sections giving special attention to priority populations. Increase caseload review by primary clinician from semi-annually to quarterly.
7	Increase penetration rate for rural children with SED from 32% to 45 %. Review a sampling of medical records of children in identified rural counties to determine if they are correctly identified with an SED marker when applicable. Identified IMPACT staff will conduct two or three education sessions with schools, DJJ and DCBS staff in the identified counties regarding outpatient and IMPACT services available.
8	Staff shall participate in at least four educational programs via teleconferencing during the 2005 fiscal year. Obtain schedules of educational opportunities via teleconferencing from UK and other sources. Schedule appropriate clinical staff to participate in teleconferencing sessions, document training events for contact hours/CEUs when applicable.
12	Design a natural helping mentor model for the rural population. Explore existing natural helping mentor models and identify a model to pilot. Receive training in the chosen model and begin implementation in at least one county.
14	Maintain current level of service provision in each county. Each of the ten counties will offer a summer program. Identify and serve at least ten clients age 18 transitioning from IMPACT services into adulthood.

STATE PERSPECTIVE

The two most common barriers to mental health services in rural areas are the isolation of families who have a child with an emotional disability and limited public transportation. Isolation can be partially attributed to the geographic distance between neighbors, but may be more closely associated with the heightened stigma associated with mental health services in rural areas and the difficulty of ensuring confidentiality and anonymity in a small, closely-knit community.

Limited public transportation contributes not only to service access problems, but also increases the cost of services. KDMHMRS and Kentucky Medicaid allow Regional MH/MR Boards to recover transportation costs as an allowable service delivery cost. Additionally, Kentucky Medicaid clients can receive direct reimbursement of transportation costs. The Human Service Transportation Delivery Program pools existing public transportation funds including Medicaid non-emergency transportation. A total of 16 transportation regions statewide operate 24 hours a day/seven days a week with a single broker or broker/provider established in each region. Consumers access transportation services through a toll-free phone number. When no other source of funding is available to IMPACT clients, wraparound funds may be used to pay transportation costs, or if appropriate, costs to repair or secure an automobile.

Telepsychiatry networks that extend throughout Eastern Kentucky have been developed by Bluegrass Regional MH/MR Board and the Department of Psychiatry at the University of Kentucky. These networks deliver consultation and direct services to children and their families who are unable to travel. They also allow for “expert” consultation assistance to rural providers. (Refer to map of Telehealth Networks of Kentucky in Adult Criterion 4.) Likewise, telemedicine technology has enabled closer communication among regional mental health administrators and state personnel in the implementation of a federal grant which is serving to improve access and service capacity in three Appalachian regions in Eastern Kentucky.

The advantages of establishing a teleconferencing capability across rural areas are well known. Due to difficulties in recruiting qualified medical and clinical staff to work in more rural areas, teleconferencing can be used to extend staff coverage from a central site to outlying rural clinics and other service sites. Specialized services (e.g. therapists who are fluent in sign language) could be effectively extended through the use of teleconferencing.

Simplified Access to Commonwealth Service provides resource access via the Internet. Consumers, family members and providers can access the website at www.KyCARES.net and obtain information on any number of physical health and behavioral health services.

One strategy to address rural access problems is the recruitment and development of family support staff, who are parents of children with severe emotional disabilities. These parents are responsible for facilitating a regional network of parent-to-parent support and advocacy, which provide informal connections between parents to supplement kinship networks.

A third distinct problem is the difficulty of recruiting staff to work in the rural areas, which limits the capacity to expand and create alternative, non-traditional services. This is also discussed in Section II of this document as well as, in Criterion 5 of this Section. KDMHMRS is also involved with the implementation of a HRSA grant recently awarded to Eastern Kentucky University. Grant objectives specifically address cultural competency of the workforce in this Appalachian area of the state.

While the three problems of isolation, transportation and workforce are common to rural areas, each rural community has its own unique problems because of cultural, geographic and social differences. Thus, the strategies to address them must be collaborative among local, regional and state level stakeholders.

PERFORMANCE INDICATOR

1. Penetration Rate--Rural Children with Severe Emotional Disabilities

Value:	Percent
Measure:	Percentage of the number of children with SED, in rural counties, who are annually served by a Regional Interagency Council or a Regional MH/MR Board.
Numerator:	Unduplicated sum of children served during the SFY by a Regional Interagency Council, and children with an SED marker who received a Regional MH/MR Board service, who live in a rural (non-MSA) county.
Denominator:	Five percent of the Kentucky child census in rural (non-MSA) counties.

ACTION PLANS

Building on the strengths of rural communities and collaborating with other child serving agencies is seen as the best strategy for addressing mental health needs of children and families in rural areas. By truly listening to families as they express needs and preferences for service delivery, planners are learning to build on local resources like schools and community colleges and community centers where they exist to address the multiple and often complex needs of children and families.

- **State Objective C-4-1:** Offer technical assistance to regions to improve tracking of homeless youth in the KDMHMRS information data system.
- **State Objective C-4-2:** Incorporate best practices for rural service delivery into existing KDMHMRS sponsored training events and technical assistance meetings with program supervisors (e.g., Mental Health Institute, Choices and Changes Conference, Children's Services Directors and Local Resource Coordinators Peer Group meetings).

Comments from the Mental Health Planning Council meeting on August 19, 2005:

Comment: Why do regions not mark kids right?
Response: We believe that several factors may contribute to this. Perhaps clinicians do not remember to go back and change designation (to SED) after full assessment is completed and the determination has been made. Staff (clinical and clerical) may need additional training and to be reminded about the importance of the SED marker in the client record and in the data set.

Comment: A mandatory diagnosis is made on first visit so they can bill Medicaid
Response (Medicaid): A diagnosis is not required until after the 3rd visit.

Criterion 5: Management Systems

The plan describes the state's financial resources, staffing, and the training of mental health service providers (including providers of emergency services) that are deemed necessary for plan implementation. The plan also describes the manner in which the state intends to expend the mental health block grant for FY 2005.

GOAL: To ensure that there are adequate financial, staffing and training resources to enhance the children's system of care in the state.

INTRODUCTION

This criterion addresses three critical components of the overall management for implementing the system of care that serves children with SED and their families. These components include: Financial; Workforce; and Training. As it is with many other states, Kentucky struggles to maintain and improve performance with serious financial constraints and workforce shortage issues. Thoughtful and collaborative planning is key to moving the system forward in the face of such challenges.

Offered below is discussion about the current status of the three components for this Criterion. Goals and planning strategies are again offered collectively at the end of the Criterion under Action Plans.

Component 1: Financial

REGIONAL PERSPECTIVE
Regional Boards have been hard hit financially in the past year in several salient ways. Included are:

- Moderate funding cuts from the Department (approximately 2.5%in SFY 2004 and an additional 2.5% in SFY 2005);
- Frozen Medicaid rates for key services, including Case Management;
- Increases in costs to provide health insurance for their employees; and
- Increases in the percentage employers must pay towards retirement plans.

During the annual Plan and Budget application process in April 2004, the Regional Boards reported the following in their respective region:

Region	Plan for Development for SFY 2005
2	Integrate all Children's Services in the same location for children in Christian county. Relocate First Steps Office and Early Childhood mental health office to main campus.
7	Initiate grant with DJJ entitled "Building Family and Community Resources" and serve projected number of youth in year one. Two Functional Family Therapy (FFT) staff will be identified and receive required FFT training, and develop criteria with forms for utilization in the program. One half of projected number of clients will start the program with 75% completing the identified three (3) phases of treatment.
8	Cross train school-based clinicians on substance abuse prevention, assessment and pretreatment skills for use as part of the school-based program for substance abusing children. Formulate a plan for training at least 6 staff on basic prevention, assessment and pre-treatment services. Complete a grant application to the Greater Cincinnati Health Foundation on Adolescent Substance Abuse services to include Functional Family Therapy and an Intensive Outpatient program.

STATE PERSPECTIVE
This marks the third year for Kentucky's revised "flexible funding" Plan and Budget application process. As described in Section I of this grant application, Regional Boards are required by statute and contract to provide a core array of services and are held accountable to selected performance indicators for their Children's Systems of Care, but are given autonomy (where possible) in how funds are distributed based on regional priorities. There were no new appropriations from the Kentucky General Assembly specific to children's services, in the 2005-2006 biennium budget proposal.

SFY 2005 Financial Resources Summary – Children's Services

The following table summarizes the financial resources available for SFY 2005 to support the comprehensive array of children's mental health services:

SFY 2005 ALLOCATIONS	
Fund Source	**Amount**
Restricted MH General Fund & Decriminalization	$10,511,779
Flexible MH General Fund & Community Care Support	$2,723,087
CMHS Block Grant	$1,924,381
Bridges	$361,338
Early Childhood Mental Health Initiatives	$882,000
Community Medications	$66,000
IMPACT Plus (Medicaid)	$22,371,488
Medicaid	$49,175,011
Other Local	$7,049,987
Total Children's Allocations	$93,065,071
Funds allocated for services to either Adults or Children ($769,924) are not included in the above total.	

SFY 2005 CMHS Block Grant Allocations

The following table illustrates how the CMHS Block Grant funds are being allocated for services to children with severe emotional disabilities in SFY 2005 by the components of the array discussed in Criterion 1:

Component	**Block Grant Amount**
Family Involvement & Support	$127,640
IMPACT	$10,000
MH Outpatient Treatment	$890,875
MH Intensive Treatment	$101,208
Service Coordination & Wraparound	$139,963
Crisis Stabilization	$413,766
Other (may Include training, etc.)	$109,254
System Interface	$131,675
Total SED	**$1,924,381**
CMHS Block Grant Funds allocated to Regional Boards for services to either Adults or Children ($133,088) are not included in the above total.	

SFY 2005 Funded Entities – Children's Services

The table below shows SFY 2005 CMHS Block Grant funding by funded entity.

TABLE A	
Region/Contract	**Amount of Children's CMHS Award for SFY 05/FFY 04**
1 – Four Rivers	$67,603
2 – Pennyroyal	77,227
3 – Green River	81,671
4 – LifeSkills	109,346
5 – Communicare	98,609
6 – Seven Counties	436,040
7 – NorthKey	151,690
8 – Comprehend	54,030
10 – Pathways	168,164
11 – Region XI (Mountain)	69,486
12 – Ky River	88,904
13 – Cumberland River	95,974
14 – ADANTA	69,644
15 – Bluegrass	342,493
EKU	13,500
TOTAL	**$1,924,381**

*Funds allocated to provide MH services For either Adults **or** Children (not included above)*	$133,088

A list of funded entities is provided on the following page. These entities will be funded with FFY2004 and FFY2003 carryover consistent with priorities of the Mental Health Services Planning Council and the Department's plan and budget process.

Funded Entities

Regional MH/MR Boards

Region 1
Four Rivers MH/MR Board, Inc.
1526 Lone Oak Road
Paducah, Kentucky 42003

Region 2
Pennyroyal Regional MH/MR Board, Inc.
P O Box 614
Hopkinsville, Kentucky 42241-0614

Region 3
River Valley Behavioral Health
P O Box 1637
Owensboro, Kentucky 42302-1637

Region 4
LifeSkills, Inc.
P O Box 6499
Bowling Green, Kentucky 42101-6498

Region 5
Communicare, Inc.
1311 North Dixie Avenue
Elizabethtown, Kentucky 42701

Region 6
Seven Counties Services, Inc.
101 W. Muhammad Ali Blvd.
Louisville, Kentucky 40201

Region 7
NorthKey Community Care
P O Box 2680
Covington, Kentucky 41012

Region 8
Comprehend, Inc.
611 Forest Avenue
Maysville, Kentucky 41056

Region 9/10
Pathways, Inc.
P O Box 790
Ashland, Kentucky 41100

Region 11
Mountain Comp. Care Center
150 South Front Avenue
Prestonsbug, Kentucky 41653

Region 12
Kentucky River Community Care
P O Box 794
Jackson, Kentucky 41339-0794

Region 13
Cumberland River Comp. Care Center
P O Box 568
Corbin, Kentucky 40702

Region 14
The ADANTA Group
259 Parkers Mill Road
Somerset, Kentucky 42501

Region 15
Bluegrass Regional MH/MR Board, Inc.
P O Box 11428
Lexington, Kentucky 40574

Other Funded Entities

Eastern Kentucky University
100 Stratton Building
Richmond, Kentucky 40675

Kentucky Housing Corporation
1310 Louisville Road
Frankfort, Kentucky 40601

Component 2: Workforce

REGIONAL PERSPECTIVE
In the SFY 2005 annual Plan and Budget applications from the Regional Boards the following staffing patterns were reported:

- All but one region has a designated Children's Services Director;
- There are 1,345 staff assigned solely or at least 50% (of their time) to children and youth programs/services, with a range among regions of 10 to 400;
- Included in the 1,345, there are 39 child psychiatrists (with at least one year of specialized child training). Additionally, there are some regions that utilize residents working under the supervision of child psychiatrists and there are some adult psychiatrists serving older adolescents (not counted in the numbers above);
- There are 239 Service Coordinators statewide, with a range among regions of 5 to 39;
- There are 63 full-time and 162 part-time Therapeutic Child Support staff statewide;
- All fourteen regions have a designated Early Childhood Mental Health Specialist for mental health services for children age birth to five years (other than their Children's Services Director); and
- Over 150 clinicians statewide have training and experience in serving children age birth to five years.

During the annual Plan and Budget application process in April 2004, the Regional Boards did not report Plans for Development specific to workforce development.

STATE PERSPECTIVE
KDMHMRS contracts directly with each Regional Board to provide direct services and each Board employs the actual service providers. Thus, human resource development activities for the Regional Boards and their staff by KDMHMRS have traditionally been indirect, focusing on staff training, technical assistance and the establishment of minimum qualifications and core training requirements for providers. The Department continues in these roles but also recently has taken on a larger, more direct role in addressing the shortage of behavioral health care providers in the state. KDMHMHRS is collaborating with Regional Boards and colleges and universities, as well as other key stakeholders to develop immediate and long-term strategies to address the shortages of qualified behavioral health professionals in Kentucky. This is discussed in greater detail in Section I of this grant application.

The Olmstead State Plan Committee has been addressing human resource issues in their deliberations. The availability of trained professional and paraprofessional staff has critical implications for the successful transitioning of individuals to the community from institutions. Of particular concern is the supply of personal care attendants (for individuals with co-occurring physical disabilities) and the supply of residential support staff. Job profiles are currently being created for several positions within the children's community-based services arena to determine workforce needs to meet demands as outlined in the Plan.

Component 3: Training

REGIONAL PERSPECTIVE
Regional Boards reported the following in their SFY 2005 Plan and Budget applications with regard to training of staff:

- All fourteen regions provide specialized training (beyond training required of all agency personnel) for crisis services staff;
- Nine of fourteen regions report that they provide training for Emergency Services personnel. Each of these nine regions train Police, and two also train Fire and EMS;
- Most regions report that staff has regularly scheduled time for consultation with child psychiatrists and other specialists within their own agencies.
- All regions provide training to their Service Coordinators beyond the required certification training; and
- All regions take advantage of the funding available for specialized training in Early Childhood Assessment/Treatment for their designated Early Childhood staff. These Specialists are expected to further train other Board staff throughout their regions, as well as offer training and consultation to the staff other child serving organizations (e.g., early childhood centers, educators).

During the annual Plan and Budget application process in April 2004, the Regional Boards reported the following in their respective region:

Region	Plan for Development for SFY 2005
1	Provide advanced training to clinical practitioners on co-occurring issues (MH/substance abuse and MH/mental retardation)
3	Physical Health: Complete physical history on all new clients. Refer clients to appropriate physician.
4	Increase services to clients with co-occurring disorders. Provide training on identification and treatment of co-occurring disorders and specifically client centered approaches.
5	Increase the total number of referrals for MH services at point of entry (birth0 3 aged children with or without developmental delay, by 6-30-05. Complete integration of First Steps services into MH Children's Services. Provide in-service training to Service Coordinators regarding MH services.
6	Increase number of youth assessed by the Global Assessment of Individual Needs (GAIN) to ensure a holistic assessment across domains. Track children assessed at 6 and 12 months. Increase number of GAINs completed by other LANSAT (substance abuse program) providers.
8	Cross train school-based clinicians on substance abuse prevention, assessment and pretreatment skills for use as part of the school-based program for substance abusing children. Formulate a plan for training at least 6 staff on basic prevention, assessment and pre-treatment services. Complete a grant application to the Greater Cincinnati Health Foundation on Adolescent Substance Abuse services to include Functional Family Therapy and an Intensive Outpatient program.
9/10	Enhance collaboration with other agencies. Attend local continuity of care meetings.
11	Conduct at least one meeting with each of the Health Departments in the region. Share information about services that are available through public health and discuss services available through community mental health. Strategize ways in which to utilize the expertise of other agencies in providing services to mutual and future clients.
12	Explore implementation of an assessment tool that will assist in better identification of the bio-psycho-social needs of a child/youth. Explore existing assessment tools and choose a tool to be implemented. Pilot the implementation of the assessment tool as the bio-psycho-social assessment in at least one county.
13	Develop a structured format to assess, plan, and develop treatment goals/care and evaluations of physical and MH needs with a special emphasis on childhood obesity and physical fitness and mental well being. Evaluation of current assessment tools which identify physical and mental health needs. Develop or add to current assessment tools a structured format to address physical health issues that are related to child's mental health, by December 2004. Present a completed structured format to medical records for review and approval by February 2005.
14	Cross train clinical staff in non-primary focuses of clinical training. Cross-train at least 5 Service Coordinators in Early Childhood issues and strategies. Provide access to all children in each county one professionally trained substance abuse/mental health professional for consultation, assessment and treatment recommendations.
15	A training on early childhood mental health/behavioral disorders will be delivered to primary care providers. Training curriculum will be developed and training package will be delivered at one pilot site.

STATE PERSPECTIVE

There are many training events provided to staff using KDMHMRS funds allocated to the Regional Boards. Most often, such training events are made available to staff from other regions and other child serving agencies. There are also training opportunities for Regional Board staff available through the Sexual Assault and Domestic Violence program within other state agencies within the Cabinet (e.g., training events on treatment for children affected by trauma and abuse, physical health issues, domestic violence, child welfare protocols, etc.).

KDMHMRS retains a small amount of children's block grant funds to support statewide children's training initiatives geared towards the needs of children's mental health services staff who serve children with SED, and their families. The Department conducts some of these events and some are those of other agencies/entities that the Department helps sponsor with staff and/or financial resources.

The following table displays the Children's training initiatives slated for SFY 2005:

Division of Mental Health and Substance Abuse Sponsored/Provided Training Events

Type of Training	Intended Audience	# of Participants Anticipated	Frequency/ Length of conference
*Mental Health Institute Pre-Conference on Medication Algorithms	Behavioral health providers and administrators, consumers and family members	Approximately 1,000 Approximately 300	Annually 2.5 days 9/29-10-1/04 9/28/04
*Choices and Changes Conference Pre-Conference on Transition Services	Providers of children's behavioral health services, case managers, school personnel, community child serving agency personnel, consumers and parents	Approximately 800 Approximately 300	Annually 2.5 days 3/29-31/05 3/28/04 (Tentative)
Kentucky School of Alcohol and Other Drug Studies	Behavioral health providers and administrators, consumers and family members	Approximately 1,000	Annually 4.5 days 9/29-10-1/04
Service Coordination 101 Certification (required for providers)	Prospective providers of Children's Targeted Case Management services (IMPACT and IMPACT Plus)	Approximately 25-35 per session	6 times/ year 2.5 days each
Local Resource Coordinator Technical Assistance Meetings	Supervisors of children's Targeted Case Management service providers	Approximately 25	Quarterly
*Kids are Worth It! Conference (Co-Sponsored by DMH)	Behavioral health providers, teachers, advocates, police, attorneys and social services staff	Approximately 500	Annually
*Question, Persuade, Refer (QPR) Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Varies depending on location across the state	At least four times per year
*Cultural Competency Training of Trainers	Current and prospective providers of Cultural Competency Training at the KDMHMRS operated or contracted facilities and Regional MH/MR Board staff and KDMHMRS central office staff	Approximately 20	Four times per year and upon request
Train the Trainers Suicide Prevention in the Jails	Jailers and Regional MH/MR Board staff	Varies depending on location across the state	At least two times per year
Deaf Awareness Trainings	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Ranges from 5-125 per session	Typically once per month and also on a PRN basis
TTY Assistive Listening Devices Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and KDMHMRS central office staff	Ranges from 5-125 per session	Typically once per month and also on a PRN basis
What Is Mental Health Training	Kentucky Association for the Deaf	Up to 200	Annually
Domestic Violence and Deafness Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and central office staff	Approximately 60	Annually

*HIV/AIDS Training	Behavioral health service providers, state operated or contracted facilities, consumers, local interest groups and KDMHMRS central office staff	Ranges from 5-125 per session	Annually

*Denotes that Continuing Education Units (CEUs) are offered for these training sessions.

Mental Health Institute (MHI)
The annual Mental Health Institute serves as the major KDMHMRS training event for mental health service providers and consumers and family members. This statewide conference features approximately 60 workshops covering a wide variety of topics from Prevention, Treatment, Rehabilitation and Recovery, to Administration. The fifteenth Mental Health Institute will be held on September 29- October 1, 2004. The theme of this year's Institute will be "Promoting Recovery through System Transformation" and it will again focus on evidence-based practices.

Choices and Changes
The annual Choices and Changes conference is a collaborative training event of KDMHMRS, Office of Family Resource and Youth Services Centers, and the Center for School Safety and the Kentucky Department of Education. It is specifically geared towards those who work with children and families across a wide variety of settings including home, school and community. Traditionally, a training and networking event for IMPACT and IMPACT Plus service providers, it has gained a wider focus and audience in recent years.

Kentucky School of Alcohol and Other Drug Studies
The annual Kentucky School has traditionally been the premier training event for those working in the substance abuse arena but it too has grown to include a wider audience and a broader focus to include professionals from a variety of disciplines. There are intensive sessions on a variety of topics including Adolescent Substance Abuse and Co-Occurring Disorders.

Service Coordination Certification Training 101 (SC 101)
As mentioned previously, all targeted case managers serving children with SED must complete a required certification training within the first six months of their employment. This is true for IMPACT and Bridges Project Service Coordinators and IMPACT Plus Case Managers. A team of individuals has been convened to serve as "faculty" of this curriculum, including KDMHMRS, SIAC, and IMPACT Plus central office staff, IMPACT and IMPACT Plus field staff. The faculty has studied and refined the curriculum and seeks to continually improve upon the content and delivery of the information deemed most relevant. This group is enthusiastic about follow-up training and support for case managers and it is hoped that staff retention will be affected by the work they are doing. This faculty is also involved with the planning and refining of additional training for IMPACT and IMPACT Plus staff.

Cultural Competency Training
The Department sponsors cultural competency "train-the-trainers" sessions twice per year for interested Regional Board and facility staff. The training uses a curriculum first developed in SFY 1997, but continually updated. Additionally, two seminars, targeted for KDMHMRS central office staff and regional trainers, are also provided on an annual basis.

Training of Emergency Services Personnel
Each Regional Board receives funding from KDMHMRS to support decriminalization of the mentally ill services for children. In addition to assessment and evaluation activities with children, Board staff are responsible for educating emergency services personnel (the courts, peace officers, inpatient psychiatric facilities, Rape Crisis Centers, etc.) as to applicable statutes concerning involuntary hospitalization and how to access evaluation services on a 24-hour per day, seven days a week basis.
In addition to these statewide conferences and workshops, the Department uses these funds to provide scholarships (limited) for parents and Regional Board staff to attend events such as the Mental Health Institute or Choices and Changes. Funds may also be expended to support technical assistance meetings to support on-going and developing children's programming (e.g. Therapeutic Foster Care, Day Treatment).

With regard to the revised Plan and Budget process, the Department has attempted to balance flexibility with guidance so as to ensure Regional Boards' ability to endure increasing demands while experiencing minimal funding increases. Regional Boards have been engaged from the beginning in planning meetings regarding the revised process. Also, a Plan and Budget Orientation session was conducted for administrators who are charged with completing the applications.

CMHS Block Grant funds are subcontracted by the Department to Regional Boards based on an approved Plan and Budget. The Plan and Budget is the basis for the contractual agreement between the Department and Regional Boards to provide services that are consistent with fund source requirements, departmental priorities, service definitions and standards.

Regional Boards may also subcontract with an appropriate community agency to provide services. Such proposals must first be submitted to and reviewed by the Program Planning and Evaluation Committee of the Regional Board in accordance with their established subcontracting procedures.

PERFORMANCE INDICATOR

1. Per Capita State Mental Health Expenditures: Restricted Children's Spending
   Value: Rate (dollars per child with SED per year)
   Measure: Restricted KDMHMRS children's funding per capita child.

ACTION PLANS

KDMHMRS continues to keep abreast of workforce development issues and strategies from other states and other professions (e.g. teacher shortages). Continued collaboration efforts among stakeholders is considered key to better align the needs of Regional Boards with the requirements of the professional licensure boards, and the curriculum used at the universities and colleges with behavioral health degree programs. Exploration of techniques in marketing of the field, web-based learning, and flexible and collaborative funding are strategies considered promising for Kentucky.

In an effort to enhance competency across the state, the Department continues to offer specialized "Training of Trainers" (TOT) concerning cultural competency for staff of Regional Boards and facilities. Additionally, the Department includes cultural diversity topics in all major training events held throughout the year.

- **State Objective C-5-1:** Secure funds from all available sources (federal and foundation grants, state general funds, training and research grants, etc.) to encourage the implementation of evidence-based practices across the state.
- **State Objective C-5-2:** Assist regions with developing evidence-based treatment protocols for specific mental health disorders and co-occurring disorders in children and youth.
- **State Objective C-5-2:** Support the establishment of a sustainable suicide prevention effort, steered by a stakeholder group that improves public awareness, has a training component and is research driven.

Comments from the Mental Health Planning Council meeting on August 19, 2005:

Comment: You need to require IMPACT Plus providers to submit data (to RDMC) like the Centers have to because we are not getting credit for all those served through IMPACT Plus.
Response: I do not believe that we have a way to require that of them like we do with the Centers through our contracts.